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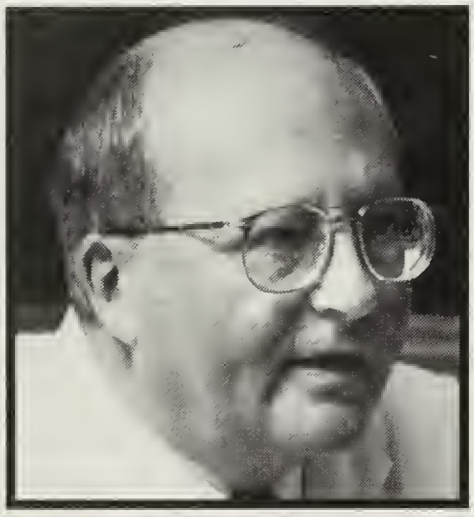
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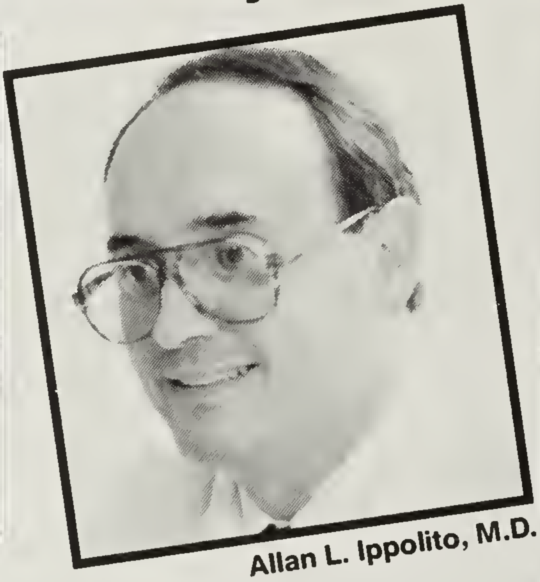
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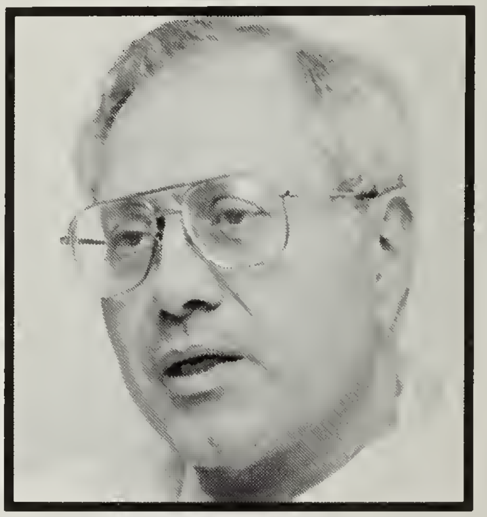
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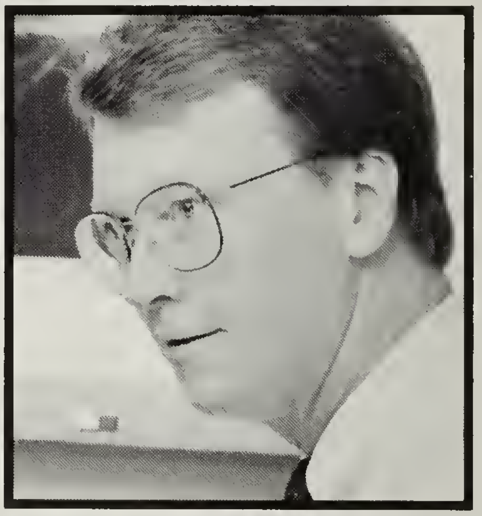
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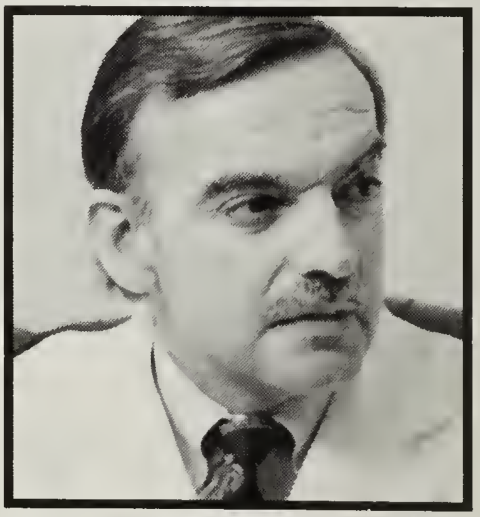
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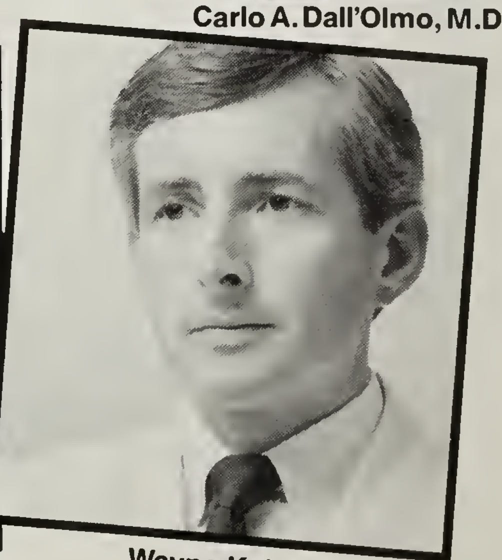
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MICHIGAN MEDICINE

14 **COVER STORY**
"Maternal/Child Health: A Critical Balance" is the theme of this year's Michigan Conference on Maternal and Child Health slated for March 13-14 at the Ritz Carlton Hotel, Dearborn. This month's cover story features a complete preliminary program and registration form for this not-to-be-missed event.

Page 14

FEATURES

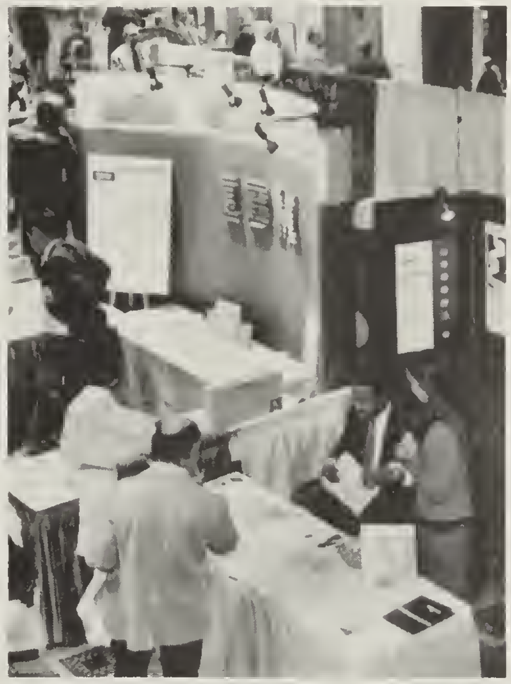
22 **MSMS ANNUAL SCIENTIFIC MEETING**
Three pages of photo highlights.

25 **PHYSICIANS HAVE GREATEST AUTHORITY ON ENVIRONMENTAL HEALTH**
Recap of the three-hour Annual Scientific Meeting panel discussion on "Caring for the Environment."
– BY CLAUDIA SKUTAR

29 **HISTORY OF MICHIGAN MEDICINE AND OTHER MSMS JOURNALS**
A look back at the evolution of Michigan Medicine.
– BY HERB AUER

33 **A CLOSER LOOK AT MSMS INSURANCE PROGRAMS**
An explanation of the MSMS health insurance program administered by the MSMS Group Insurance Trust, plus detailed charts listing the benefits offered physicians and their employees.
– BY VALERIE BARKER

37 **BOARD OF MEDICINE ACTIONS**



Page 22

DEPARTMENTS

7 Letters
9 Newsfronts
10 Physicians in the News
39 New Members
40 Deaths
42 Category I Courses
47 Meetings
51 Classifieds
53 Advertising Index
56 President's Page
"Alternative forms of dispute resolution – We must be clear on what we want"
BY SUSAN H. ADELMAN, MD

Page 25

In next month's issue of *Michigan Medicine:*
Physicians working with local health departments.
Cover illustration by: *Robert L. Brent.*

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The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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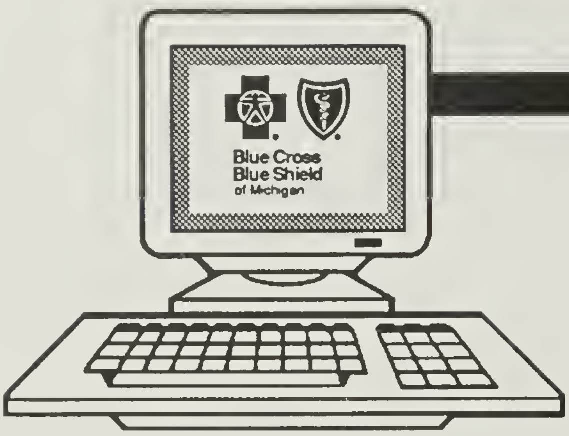

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Letters from Our Readers

Readers would benefit from hearing dissenting view of Low Level Radioactive Wastes Compact

The Genesee County Medical Society would like to congratulate *Michigan Medicine* for the December issue. It was packed with information on topics in which the GCMS has a very strong interest: living wills and low level radioactive waste disposal.

We noted that *Michigan Medicine* published a letter from the AMA on safe disposal of radioactive wastes, encouraging support of implementation of the Low Level Radioactive Wastes Compact. We feel that *Michigan Medicine* readers would benefit from the dissenting view of the Genesee County Medical Society mailed to James Todd, MD, AMA executive vice president, recently.

The letter reads:

"Thank you for your recent communication on the issue of radioactive waste disposal. The Genesee County Medical Society of Flint, Michigan, addressed this issue over one year ago by appointing an Environmental Health Committee. *The position paper developed by the committee and unanimously adopted by our county society board is in opposition to any such site in Michigan for several reasons.* I outlined them in an article published in Michigan Medicine in July, 1990, and I have enclosed a copy for you.

"This is a very serious and complex issue. A survey by the Michigan Department of Public Health in January, 1990, shows that 15 percent by volume (not 25-30 percent) of the waste for such a site is produced in medical therapeutics and research. However, the remaining 85 percent by volume of the 'low level' waste coming out of the power industry contains very different isotopes from those we use in medicine and these isotopes are highly toxic and long-lived. The major contaminant is cesium 137, a very biologically-active isotope with a required degradation time of approximately 300 years. Medical radioactive waste can be greatly decreased by diminishing the waste stream: using shorter-lived isotopes and creating two-year holding areas that would allow most of it to completely degrade. The power industry is producing a much more dangerous waste product and the debate should be focused around that fact.

"We would agree with you that it is a political issue as well as an environmental one. However, our opinion is that the environment is too often sacrificed for political concerns. State medical society delegates from Ohio brought the issue to the AMA House last June because the Nuclear Regulatory Commission was willing to ignore its own guidelines in order to find a disposal site in Michigan. If you live in Illinois, you must be aware of the series of events in that state leading to the dismissal of the director of the Illinois Department of Nuclear Safety. Data on the aquifers under a proposed disposal site was purposely falsified in an attempt to locate the dump facility in a particular area. These events suggest that the politics of radioactive waste disposal are very likely to ignore significant environmental concerns.

"Finally, the BEIR V report was published by the National Academy of Sciences in December, 1989, and it stated flatly that the risk of cancer from exposure to low-level radiation exposure is four to five times higher than previously realized. Such data simply cannot be ignored and it completely supercedes the AMA's report in August, 1989. In fact, a group of physicians in New York have calculated predicted risk at the "fenceline" of a radioactive waste facility on the basis of BEIR V and it exceeds "de minimis" standards by a factor of ten.

"Our opinion is that the 1980 legislation urging state "compacts" is seriously flawed and must be repealed. It is not in the interest of the public's health to have 15-20 sites around the country where further radioactive contamination can occur. As we stated in our article in *Michigan Medicine:* 'The nation should search for one site to contaminate with "low level" radioactive waste, not 10-15 regional sites. Ideally, that site should be in as arid an environment as possible, with water tables as deep and isolated as possible, on land that has already been contaminated with radioactive isotopes, and on non-productive land the federal government already owns. A possible site would be the hundreds of eternally contaminated square miles that make up the Nevada bomb range.'

"We are unalterably opposed to any attempt to site a radioactive waste facility anywhere within the Great Lakes basin. We feel the AMA has grieviously erred on this issue and we would urge a complete re-evaluation of the AMA position."

Siavosh Varjavandi, MD
President
Genesee County Medical Society

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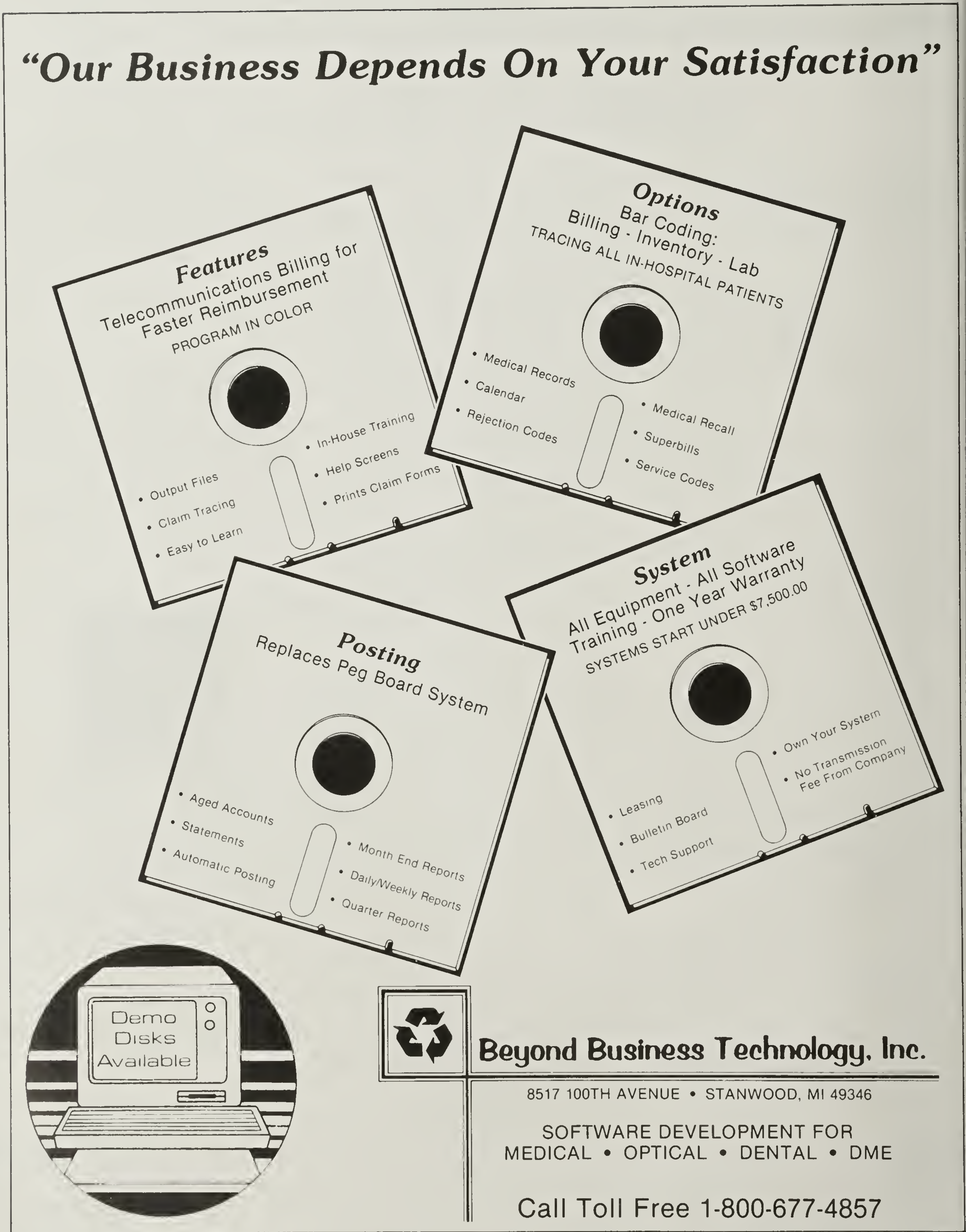

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MEDICAL NEWSFRONTS

INDEX

U-M Institute to conduct long-term study of health, retirement issues 9

Harper/WSU researchers conduct anorexia nervosa study 9

Beaumont/Oakland University team up for landmark study 9

Sinai to test new drug for Parkinson's disease 9

Too many women still not taking advantage of early breast cancer detection methods 10

Diabetes research grants available for 1991-1992 10

WSU to participate in national AIDS study 11

MDPH, local health departments to use new Lyme disease case definition, report form 11

Patients needed for Hepatitis study 11

WSU leads research on new drug to treat brain injuries 12

Sinai's Ob/Gyn residency program wins national award 12

U-M Institute to conduct long-term study of health, retirement issues

The University of Michigan Institute for Social Research (ISR) will design and conduct a long-term study of health and retirement issues in collaboration with the National Institute on Aging (NIA).

The study, projected to continue for at least 12 years, is estimated to cost approximately $10.5 million over the first five years and is one of the largest awards ever received by ISR. The U-M researchers plan to interview a sample of approximately 8,000 US families and more than 13,000 men and women in sample families.

Planning for the study will begin immediately, with the first phase of data collection scheduled to begin in early 1992.

According to F. Thomas Juster, ISR research scientist and professor of economics who will direct the study, "We plan to provide data on retirement patterns that are crucial to understanding the health and economic issues confronting policy-makers during the next several decades, when the US population will be aging rapidly."

The ISR study design, which was selected by the National Institutes of Health in a competitive process, will provide current information on the labor force activity, health status, and family responsibilities of men and women approaching retirement.

Harper/WSU researchers conduct anorexia nervosa study

Harper Hospital/Wayne State University researchers are investigating a new treatment for individuals afflicted with anorexia nervosa and bulimia. Based on preliminary studies, Mary Ann Marrazzi, PhD, associate professor of pharmacology, Wayne State University School of Medicine, and Elliot Luby, MD, chief of psychiatry at Harper Hospital, believe that anorexia nervosa and bulimia are biological addictions. The addiction is believed to be caused by heroine-like compounds released during an initial period of dieting that literally get the patients "high" on dieting.

Dieting does not trigger an addiction in most of us.

However, a biological predisposition that may trigger the addiction process may occur in some individuals. Harper/WSU researchers are using a dramatic new approach in treatment by using drugs that block the action of these compounds. The initial clinical studies look very promising and further studies are currently in progress.

Patients qualified to participate in the study must be involved or become involved in weekly psychotherapy and should continue with their therapist throughout the study. For further information on the study, contact Doctor Marrazzi at 313/577-1569.

Beaumont/Oakland University team up for landmark study

William Beaumont Hospital and the Oakland University Eye Research Institute are collaborating in a national study to shed light on the development and progression of cataracts and age-related macular degeneration (AMD).

Beaumont is the only Michigan site, and one of 11 centers across the country, participating in the Age-Related Eye Diseases Study (AREDS), funded by the National Eye Institute (NEI).

The NEI will spend $25 million on the study over the next 10 years, including a $2.5 million grant to support the Michigan study, a collaborative effort between Beaumont, where clinical work will be done, and the Eye Institute at Oakland University (OU).

"This is a landmark study — the first to track the natural history of two of the most prevalent conditions leading to the loss of vision in the elderly," said Raymond R. Margherio, MD, chief of ophthalmology and the study's principal investigator at Beaumont. "Ideally, the study results will provide future generations with the scientific basis to prevent these disabling and costly diseases. Such an outcome is highly likely because several studies already suggest that both cataracts and AMD are associated with various genetic and personal characteristics such as race, smoking, diet, nutrition and eye color."

Volunteer recruitment is underway for the study, which will include more than 4,600 participants throughout the nation, some with cataracts or AMD, and others without these eye diseases.

Participants will receive two comprehensive eye examinations annually until the year 2000. During this period, researchers will monitor and collect data on how the eyes age.

To enroll in the study, volunteers must be 60 to 75 years old and must complete a preliminary eye examination by AREDS staff.

Participants should have no illnesses or disorders that would make long-term follow-up unlikely or difficult and have no history of prior eye surgery. Previous cataract surgery is acceptable for participation in the AMD portion of the investigation. For more information on volunteering for the study, call 313/551-4601.

Sinai to test new drug for Parkinson's disease

The Clinical Neuroscience Program at Sinai Hospital, Detroit, is among 14 medical

Continued on page 10

Continued from previous page

centers throughout the United States set to conduct an outpatient trial evaluating a new Parkinson Disease medication.

Directing the study at Sinai is Peter A. LeWitt, MD, director of the Clinical Neuroscience Program and a nationally recognized expert in the treatment of Parkinson Disease.

The new drug will be tested for its potential value in several applications, including slowing the progression of Parkinson Disease and enhancing the therapeutic value of several available medications. This drug, currently termed Ro 19-6327, is under development by Hoffman-La Roche, Nutley, NJ. The multi-center study will evaluate its safety, tolerability, and effect on clinical symptoms of Parkinson Disease.

This study is expected to last one year and is directed at persons affected with mild symptoms of Parkinson Disease. There is no cost to patients who participate in this study. Patients can receive evaluations for Parkinson Disease and further information regarding the study by contacting Peter LeWitt, MD, at the Clinical Neuroscience Program, Sinai Hospital, 313/493-5354.

Too many women still not taking advantage of early breast cancer detection methods

Early diagnosis of breast cancer in women is increasing. However, a recent study indicates that there are still too many women, especially blacks, who are not taking advantage of early detection methods.

This is among the findings of an extensive study of breast cancer incidence in the metropolitan Detroit area by a team of health care professionals headed by G. Marie Swanson, MD, director of Michigan State University's Comprehensive Breast Cancer Center.

The study analyzed 17,216 cases, reported between 1978-87, in which women were diagnosed with breast cancer. One of the goals of the project was to determine how many women had the cancer diagnosed early, a key to treatment and recovery.

The study found that in 1978, nearly 18 percent of the breast cancers diagnosed in the Detroit area were categorized as early.

In 1987, that figure rose to 32.7 percent.

"That's a step in the right direction," said Doctor Swanson.

"But in contrast to the proliferation of mammography facilities, we should see a much bigger increase."

Among women under 50, the mortality rate in blacks is 9.5 per 100,000, compared to 6.1 in whites.

Doctor Swanson's article, "Racial Differences in the Early Detection of Breast Cancer in Metropolitan Detroit, 1978 to 1987," appeared in a recent edition of the publication *Cancer.*

Co-authors of the report were Enid R. Satariano of the Michigan Cancer Foundation's Division of Epidemiology; William A. Satariano, MD, of the University of California-Berkeley School of Public Health; and Barbara A. Threatt, MD, of the Comprehensive Breast Cancer Center, Ann Arbor.

Diabetes research grants available for 1991-1992

The Juvenile Diabetes Foundation International announces the availability of grants in diabetes research for the funding year September 1, 1991, to August 31, 1992.

Applications may be obtained from: Grant

Continued on page 11

Physicians in the News

Robert D. Sparks, MD, director of substance abuse programs for the Battle Creek Adventist Hospital and chairman of the board of directors of the National Council on Alcoholism and Drug Dependence, has been elected president of the Chelsea Arbor Treatment Center board of directors. The center, a joint venture between the University of Michigan Hospitals and Chelsea Community Hospital, was formed in September to care for and treat patients with alcohol and drug addictions.

George Dean, MD, Birmingham, is newly-elected vice president of the American Academy of Family Physicians (AAFP). Doctor Dean is on the staff of Harper-Grace, Providence and Beaumont hospitals. In 1985 he was named family physician of the year by AAFP.

Robert E. Paxton, MD, a Fremont family physician and former MSMS president, is a newly-elected member of the Physicians Insurance Company of Michigan (PICOM) Board of Directors. Doctor Paxton will serve by appointment on the PICOM Board until the 1991 Annual Meeting of Shareholders.

Paul T. Werner, MD, is the new chairman of the Department of Family Medicine, Wayne State University School of Medicine. Doctor Werner is also newly-named chief of family practice of The Detroit Medical Center. An associate professor of family medicine and a faculty associate in the WSU Institute of Gerontology, Doctor Werner continues as director of geriatrics within his department.

Joel R. Saper, MD, FACP, is the new president of the American Association for the Study of Headache (AASH). AASH is the nation's only professional medical society of specialists in head and face pain disorders. Doctor Saper is founder and director of the Michigan Head-Pain & Neurological Institute, Ann Arbor.

William P. Potthoff, MD, FACS, recently received a three-year appointment as Cancer Liaison Physician for the Cancer Program at Munson Medical Center, Traverse City. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Doctor Potthoff is among a national network of 2,300 volunteer Cancer Liaison Physicians who provide leadership and support to the Hospital Cancer Program, and other Commission on Cancer activities.

Continued from previous page

Administrator, Juvenile Diabetes Foundation International, 432 Park Avenue South, New York, NY 10016, 212/889-7575.

Each grant application is subject to scientific peer review by the Medical Science Advisory Board and approval by the International Board of Directors. These bodies evaluate the scientific merit of the application; the qualifications, experience and productivity of the investigator; the facilities available; and the relationship of the research to the cause, cure, treatment and/or prevention of diabetes mellitus and its complications.

Completed applications must be received not later than March 1. One copy of the first two pages of the application must be received not later than February 15.

WSU to participate in national AIDS study

Two national AIDS studies are to take place at clinics around the country including the Comprehensive AIDS Alliance of Detroit, a coalition of community and hospital physicians based at Wayne State University. Lawrence Crane, MD, associate professor of medicine at WSU and section chief of infectious diseases at Harper-Grace Hospital, is principal investigator of the WSU studies.

One project, conducted by the Community Clinical Programs for Research on AIDS (CCPRA) of the National Institute of Allergy and Infectious Diseases (NIAID), will compare the effectiveness of two drugs to prevent toxoplasmic encephalitis.

The study will compare clindamycin and pyremethamine, two-widely available drugs which, based on previous experience, "offer promise for preventing or delaying toxoplasmic encephalitis in HIV-infected persons," concluded Anthony S. Fauci, MD, NIAID director.

"Toxoplasmic encephalitis is a common and important disabling disease in our patients," reported Doctor Crane. In fact, caused by the parasite *Toxoplasma gondii*, it is the most common opportunistic infection of the brain in persons with AIDS. Nearly all cases in AIDS patients result from reactivation of a previously latent *T. gondii* infection. Approximately 30 percent of adults have been infected with the parasite at some time in their past, usually from eating raw or poorly cooked meat or through contact with cat feces.

In healthy persons, *T. gondii* generally causes mild or no symptoms. In AIDS patients, toxoplasmic encephalitis results which is invariably fatal if left untreated.

The toxoplasma study will be conducted by investigators affiliated with the 18 CPCRA sites in 14 US cities, and is expected to last approximately three years. The study will enroll 750 patients nationally to be followed for a minimum of 24 months. Participants must be 13 years of age or older, and both men and non-pregnant, non-nursing women may enroll. All participants must be HIV positive or be diagnosed with an AIDS-defining illness, and have a T4 cell count below 200. They must have toxoplasma antibodies, but no history of *T. gondii* disease of the eyes, lungs, or control nervous system. Persons with AIDS dementia or any other neurologic symptoms except for peripheral neuropathy will be excluded.

Physicians affiliated with any of the CPCRA sites may enroll their patients in the study. Persons interested in this clinical trial may call Doctor Crane, Wayne State University, at 313/933-0934, or 1-800-TRIALS-A.

NIAID is co-sponsoring a second study along with the American Foundation for AIDS Research (AmFAR). The purpose of the Observational Data Base Project (ODB) is to document the progression of HIV infection in a broad spectrum of HIV-infected individuals. Several hundred primary care physicians are seeking to provide information on how infection of the AIDS virus progresses, which AIDS symptoms and related diseases are most common in different patient populations, and what treatments patients are using, including approved and "alternative" therapies. In addition, the study will help clinicians and researchers identify changing manifestations of HIV illness over time and analyze factors that appear to influence prognosis.

The study is the largest of its kind ever conducted and is expected to include several thousand patients nationally.

Subjects for the ODB project will come from the 18 Community Programs for Clinical Research on AIDS sponsored by NIAID and 24 additional programs participating in the Community Based Clinical Trials Network (CBCTN), sponsored by AmFAR. Eligible participants must be affiliated with a CPCRA or CBCTN program, be under the care of a doctor in the program, be 13 years or older, and have evidence of HIV infection or any opportunistic infection or malignancy indicative of AIDS.

Persons interested in either of the AIDS clinical trials may call Doctor Crane, Wayne State University, at 313/933-0934, or 1-800-TRIALS-A.

MDPH, local health departments to use new Lyme disease case definition, report form

Beginning with cases reported after January 1, 1991, epidemiologists in the Michigan Department of Public Health, Disease Surveillance Section, together with local health departments, will begin using the new CDC case definition to classify possible Lyme disease cases. In conjunction with this new definition is a revised Case Report Form. Local health departments will have copies of the new form. Completed case reports should be mailed back to your local health department.

Physicians should note some differences in the new version:

1. It's shorter, only one page of information is requested.
2. The criteria for erythema migrans and other systems involved have become more specific. The criteria are presented in detail on the reverse side of the Case Report Form.
3. Since many of the signs and symptoms can only be evaluated by a physician, it is very important for the physician to complete the form. Illnesses may not be counted if information needed to classify a case is lacking.

For more information, call 517/335-8165, or your local health department.

Patients needed for Hepatitis study

Detroit researchers at Hutzel Hospital/Wayne State University are looking for patients with chronic Hepatitis B to participate in a treatment program, using a new drug, Thymosin alpha 1.

The most recent Hutzel/WSU study showed that Thymosin resulted in a high rate of remission for patients, with no side effects. These patients have remained in remission for more than 27 months.

Research will begin immediately for the final phase of the study and will last two to three years. Adults with chronic Hepatitis B who are interested in participating in the study need a referral from their physician.

Continued on page 12

Continued from page 10

Milton Mutchnik, MD, is the project director and principal investigator. For more information, call Emily Smith at 313/745-7521.

WSU leads research on new drug to treat brain injuries

Researchers at the Wayne State University School of Medicine have initiated a study that may result in a major advance in the treatment of brain trauma. Trials are underway at Detroit Receiving Hospital in The Detroit Medical Center to assess the efficacy of a new drug therapy, which is hoped will dramatically improve outcomes in patients with severe head injuries.

Reports from preliminary studies indicate that the drug Tirilizad, developed by The UpJohn Company, may result in a speedier and more complete recovery for such patients. The FDA has recently cleared the way to begin Phase I clinical trials to test the drug's effectiveness on humans.

WSU professor and chairman of neurosurgery Fernando Diaz, MD, PhD, and associate professor of neurology Patti Peterson, MD, are the principal investigators for the study, which also involves 12 other research centers nationwide.

Tirilizad has been shown in animal studies to effectively decrease the extent and severity of secondary damage after initial trauma. When administered immediately after head injury — usually within four hours — Tirilizad is expected to diminish secondary damage and thus hasten recovery.

In conjunction with the drug trial, a computerized neuromonitoring system has been developed by WSU assistant professor of neurology A. Robert Spitzer, MD, to help measure the drug's efficacy. The non-invasive monitoring system will provide physicians with immediate data on the neurological effects of the drug. Previously, a drug's effects could only be monitored by the physical recovery of the patient, which often takes months and years.

The initial phase of the study will take from one to two years to complete and will involve approximately 30 patients treated at The Detroit Medical Center.

Sinai's Ob/Gyn residency program wins national award

Sinai Hospital's obstetrics and gynecology residency program has been awarded the Berlex Resident Education Award for 1991, the only winner of the award in Michigan, for its commitment and support of research in the field of obstetrics and gynecology.

Of approximately 300 obstetrics/gynecology residency programs in the United States, only one in each state wins the national annual Berlex Education Award.

The New York-based Berlex Foundation, formed in 1986, is a non-profit organization established for the purpose of fostering education and innovative research in the field of reproductive medicine.

As part of the national award, Sinai has been asked to designate one of the hospital's obstetrics and gynecology residents to participate in a January 1991 epidemiology/clinical trial design course developed specifically for the Foundation by a nationally respected faculty of experts in these fields.

Upon completion of the course, it is expected that the candidates who have participated in the course will return to their respective residency programs equipped with the tools and knowledge to share with their peers for the enhancement of their programs, and ultimately, the specialty of obstetrics and gynecology. ■

Michigan State Medical Society

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University of Michigan Medical Center

the 30th Annual Michigan Conference on Maternal and Child Health

The perinatal health care professional attending this conference will have an opportunity to interact with a multidisciplinary faculty addressing present and future concerns in maternal and child health. At the conclusion, the participant should be able to:

Obstetric Concerns

- increase provider's awareness of future trends in maternal/child care
- realize the impact of current provider reimbursement techniques, both public and private, in access to care for pregnant women
- understand the impact of quality of prenatal care on the cost of neonatal care
- identify new ambulatory care techniques in the practice of obstetrics
- update information on perinatal human immuno deficiency virus infection
- learn up-and-coming obstetric therapies and perinatal technology
- gain new information on critical care in obstetrics
- understand more about vaginal birth after cesarean section
- learn about the public health department's perspective on cost effectiveness in perinatal care

Pediatric Concerns

- be aware of the financial and social concerns affecting neonatal care
- understand the relationship between prenatal care and cost of neonatal care and the impact of reimbursement issues on delivery of care
- be familiar with the acute and chronic management of neonatal seizures
- recognize the complexities of prolonged hospital management of BPD
- understand the issues involved in preparing the high-risk neonate for discharge home, including home care planning
- be aware of the financial impact of substance abuse on neonatal care
- understand the epidemiologic factors involved in cerebral palsy
- be aware of technological advances in the NICU, including surgical aspects
- be aware of CDC policies relating to the pediatric AIDS patient
- recognize the method of diagnosis and treatment of neonatal herpes

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The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditaiton, designates this activity meets the criteria for a maximum of 11.5 hours in Category I toward the requirement for Michigan licensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Wednesday Morning, March 13

7:30 a.m.
Registration, Continental Breakfast

8:15 a.m.
General Session:

Welcome: Susan Hershberg Adelman, MD, President, Michigan State Medical Society

Moderator: Joseph S. Moore, MD, Grand Rapids, President, Perinatal Association of Michigan

8:30 a.m.
"The Future in Maternal/Child Care Begins Now" Richard Schwartz, MD, President-Elect, American College of Obstetricians and Gynecologists, Brooklyn, New York

9:15 a.m.
"Health Care Insurance Carrier/BCBSM" Fred R. Severyn, MD, Acting Medical Director, BCBSM, Detroit

9:45 a.m.
Break

10:15 a.m.
"Impact of Reimbursement on Delivery of Services" Don Snell, CEO, Hutzel Hospital, Detroit

10:45 a.m.
"Prenatal Care: The Relationship to Cost of Neonatal Care" David Gagnon, MPH, National Perinatal Information Center, Providence, Rhode Island

11:15 a.m.
Panel – All Speakers
Moderator: Doctor Moore

NOON
Adjourn to Luncheon, Posters and Exhibits

Wednesday Afternoon, March 13

Concurrent Sessions in A) Obstetrics and B) Pediatrics

A

Obstetrics
Moderator: Charles Vincent, MD, Chief, Department of Gynecology, Hutzel, Hospital, Detroit

2:00 p.m.
"Home Care" Silvio Aladjem, MD, Kalamazoo

B

Pediatrics
Moderator: Mary P. Bedard, MD, Assistant Professor, Department of Pediatrics, Wayne State University School of Medicine

2:00 p.m.
"Financial Implications of Substance Abuse," Iris E. Smith, RN, MPH, Emery University, Atlanta, Georgia

A

Obstetrics

2:30 p.m.

"Ambulatory Monitoring"
H. Frank Anderson, MD, Assistant Professor, Department of Obstetrics and Gynecology, University of Michigan Medical Center

3:00 p.m.

Break (Posters & Exhibits)

3:30 p.m.

"Birthcare and Beyond: Coping with Decreased Length of Stay"
Jeanne Driscoll, RN, MS, Independent Practice, Psychotherapy and Consultation; Vice-President, Lifecycle Production, Inc., Boston, Massachusetts

4:00 p.m.

"Prolonged Hospitalization"
Fran Dell, MSW, Department of Social Work, William Beaumont Hospital, Royal Oak

4:30 p.m.

Questions and Answers (All Speakers)

4:45 p.m.

Adjourn to Posters & Exhibits

B

Pediatrics

2:30 p.m.

"Neonatal Seizures"
Steven Donn, MD, Associate Professor, Department of Pediatrics and Section of Newborn Services, University of Michigan Medical Center, Ann Arbor

3:00 p.m.

Break (Posters & Exhibits)

3:30 p.m.

"Prolonged Hospitalization – BPD"
Steve Guertin, MD, Director, Department of Emergency Pediatric Intensive Care, Edward W. Sparrow Hospital, Lansing

4:00 p.m.

"Family Issues: Impact in the Home"
Deb Russell, Kalamazoo

4:30 p.m.

Questions and Answers (All Speakers)

4:45 p.m.

Adjourn to Posters & Exhibits

Thursday Morning, March 14

Concurrent Sessions in **A) Obstetrics and B) Pediatrics**

7:30 a.m.
Registration, Continental Breakfast

A

Obstetrics

Moderator: John Addy, MD, Associate Clinical Professor, Department of Obstetrics and Gynecology and Reproductive Biology, Michigan State University College of Human Medicine

B

Pediatrics
Moderator: David S. Sciamanna, DO, Associate Professor, Department of Pediatrics, Michigan State University Colleges of Osteopathic and Human Medicine; Neonatologist, Edward Sparrow Hospital, Lansing

A **Obstetrics**	**B** **Pediatrics**
8:30 a.m. **"CDC Policies on HIV Care/Financial Implications"** Stanley Gall, MD, Centers for Disease Control, Atlanta, Georgia	**8:30 a.m.** **"Transition to Discharge"** Craig M. Kinney, MD, Co-Director, Neonatology Unit, Butterworth Hospital, Grand Rapids and Julie Staak, RN, Discharge Coordinator, Butterworth Hospital, Grand Rapids
9:00 a.m. **"New Therapies and Technologies"** J. Patrick Lavery, MD, Bronson Methodist Hospital, Kalamazoo	**9:00 a.m.** *Epidemiology/Cerebral Palsy* Nigel Paneth, MD, Associate Professor, Department of Pediatrics & Human Developement, MSU College of Human Medicine
9:30 a.m. Break (Posters & Exhibits)	**9:30 a.m.** Break (Posters & Exhibits)
10:00 a.m. **"Critical Care"** Wesley Lee, MD, William Beaumont Hospital, Royal Oak	**10:00 a.m.** **"Respiratory Support/Technology"** Steven Donn, MD, Associate Professor, Department of Pediatrics and Section of Newborn Services, University of Michigan Medical School
10:30 a.m. **"Midwifery/A Team Concept"**	**10:30 a.m.** **"CDC Policies in Pediatric AIDS/Financial Implications"** Stanley Gall, MD, CDC, Atlanta, GA
11:00 a.m. Questions and Answers (All Speakers)	**11:00 a.m.** Questions and Answers (All Speakers)

11:30 a.m.

Adjourn to Luncheon Meetings (all concurrent sessions)

"Drugs, Tobacco and Firearms" – Jim Wardell, MD, Detroit

"Perinatal Herpes" – Dennis Murray, MD, Associate Professor, Department of Pediatrics & Human Development, Michigan State University College of Human Medicine

"HB99457, Helping Families Through the Agency Maze," Jackie Thompson, RN, Early Childhood Education, Lansing

"HIV" – Maria Patterson, MD, Associate Professor, Department of Micro Public Health, Michigan State University College of Human Medicine and MSMS AIDS Provider Education Project, East Lansing

"Unusual Perinatal Infections" – Stephen D. Barbour, MD and Laura Zuidema, MD, Butterworth Hospital, Grand Rapids

"Hypoplastic Left Heart Syndrome" – Edward L. Bove, MD, Professor, Departments of Surgery and Pediatrics & Communicable Diseases, University of Michigan Medical School

Thursday Afternoon, March 14

1:30 p.m.

General Session
Introduction/Moderator: John V. Hartline, MD, Adjunct Professor, Department of Philosophy, Western Michigan University; Neonatologist, Bronson Methodist Hospital, Kalamazoo

1:45 p.m.

"Routine Vaginal Birth After Caesarean"
James Scott, MD, Professor and Chairman, Department of Obstetrics and Gynecology, University of Utah School of Medicine, Salt Lake City

2:30 p.m

Break

2:45 p.m.

"Care and Cost-Effectiveness/Perspectives in Michigan"
Raj M Wiener, Director, Michigan Department of Public Health, Lansing

3:30 p.m.

Questions and Answers (All Speakers)

3:45 p.m.

Epilogue – Doctor Schwartz

4:15 p.m.

Adjournment

30th Annual Michigan Conference on Maternal and Perinatal Health

March 13 & 14, 1991, Ritz Carlton Dearborn

Wednesday Morning, March 13 - General Session

7:30	Registration, Continental Breakfast
8:15	Welcome
8:30	"The Future in Maternal/Child Care Begins Now"
9:15	"Health Care Insurance Carrier/BCBSM"
9:45	Break
10:15	"Impact of Reimbursement on Delivery of Services"
10:45	"Prenatal Care: Relationship to Cost of Neonatal Care"
11:15	Panel – All Speakers
Noon	Adjourn to Luncheon, Posters and Exhibits

Wednesday Afternoon, March 13 - Concurrent Sessions in A) Obstetrics and B) Pediatrics

A) Obstetrics

2:00	"Home Care"
2:30	"Ambulatory Monitoring"
3:00	Break (Posters & Exhibits)
3:30	"Birthcare and Beyond: Coping with Decreased Length of Stay"
4:00	"Prolonged Hospitalization"
4:30	Question and Answer (all speakers)
4:45	Adjournment

B) Pediatrics

2:00	"Financial Implications of Substance Abuse"
2:30	"Neonatal Seizures"
3:00	Break (Posters and Exhibits)
3:30	"Prolonged Hospitalization - BPD"
4:00	"Family Issues: Impact in the Home"
4:30	Question and Answer (all speakers)
4:45	Adjournment

Thursday Morning, March 14 - Concurrent Sessions in A) Obstetrics and B) Pediatrics

A) Obstetrics

7:30	Registration, Continental Breakfast
8:30	"CDC Policies on HIV Care/Financial Implications"
9:00	"New Therapies and Technologies"
9:30	Break (Posters & Exhibits)
10:00	"Critical Care"
10:30	"Midwifery/A Team Concept"
11:00	Question and Answer (all speakers)
11:30	Adjourn to Luncheon Meetings

B) Pediatrics

7:30	Registration, Continental Breakfast
8:30	"Transition to Discharge"
9:00	"Epidemiology/Cerebral Palsy
9:30	Break (Posters & Exhibits)
10:00	"Respiratory Support/Technology"
10:30	"CDC Policies in Pediatric AIDS/Financial Implications"
11:00	Question and Answer (all speakers)
11:30	Adjourn to Luncheon Meetings

Thursday Afternoon, March 14 - General Session

1:30	Introduction
1:45	"Routine Vaginal Birth After Caesarean"
2:30	Break
2:45	"Care and Cost-Effectiveness/Perspectives in Michigan"
3:30	Question and Answer
3:45	Epilogue
4:15	Adjournment

Advance Registration For Michigan Conference On Maternal and Perinatal Health

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Wednesday, March 13, 1991

☐ Full-Day Session ($75 includes Luncheon)
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Choose one topic for afternoon concurrent session:

☐ A: Obstetrics ☐ B: Pediatrics

WEDNESDAY TOTAL = $ ________

Tuition Schedule: Physicians, Nurses and Others:
$75 Wednesday (includes poster luncheon)
$60 Thursday (luncheon meeting optional)
Residents & Students:
No charge for full-day sessions (lunch is $15 each day)
Luncheon: $15 for All Registrants.
Checks payable to: Michigan State Medical Society

Thursday, March 14, 1991

☐ Full-Day Session
($60 not including lunch) $ ________

Choose one topic for morning concurrent session:
☐ A: Obstetrics ☐ B: Pediatrics

☐ Luncheon Meeting Optional ($15) $ ________
(indicate 1st and 2nd choices):

___ Drug/Tobacco/Firearms
___ Perinatal Herpes
___ HB99457/Agency Maze
___ HIV
___ Unusual Perinatal Infections
___ Hypoplastic Left Heart Syndrome

THURSDAY TOTAL = $ ________

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Please complete and mail with your check to MSMS, P. O. Box 950, Each Lansing, MI 48826-0950, (517) 337-1351. Confirmation of your registration will be sent to you with a reservation card.

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"Recent research has delineated early, more subtle changes in lung and immune functions. These alterations directly predispose smokers to respiratory tract infection."

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Brief Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
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MSMS
ANNUAL SCIENTIFIC MEETING
HIGHLIGHTS

More than 70 exhibitors featured their products and informational brochures at the 1990 MSMS Annual Scientific Meeting, November 6-8, at the Hyatt Regency Dearborn. Exhibitors were on hand throughout the three-day event to speak with attendees and to answer questions.

The MSMS Annual Scientific Meeting takes much planning and coordination. The 1990 event was chaired by Conrad E. Nagle, MD, and his Annual Scientific Meeting Planning Committee.

MICHIGAN STATE
MEDICAL SOCIETY

Judges of clinical posters displayed during the MSMS Annual Scientific Meeting took a moment to compare notes. They are (left to right): David R. Rovner, MD, Joan C. Stryker, MD, Robert J. Sokol, MD, and Conrad E. Nagle, MD, chairman. The clinical poster which earned first prize was entered by Clara Michael, MD, William Beaumont Hospital, Royal Oak.

Robert J. Sokol, MD, dean, Wayne State University School of Medicine, takes a moment to pose next to a clinical poster entered by two Wayne State University physicians.

John O'Brien-Bell, MD, past president of the Canadian Medical Association, provided a one hour international perspective on "Rationing Health Care" at the "early bird" plenary session Wednesday morning. About 150 physicians gathered to hear Doctor O'Brien-Bell's 7 a.m. presentation.

Physicians filled a room at the Hyatt Regency Dearborn to learn more about "Breast Examination and Breast Abnormalities." The three-hour course included a television tape, slide presentation and live model demonstration.

Continued from page 24

Always a popular course at the MSMS Annual Scientific Meeting is "Basic Cardiac Life Support," taught by Robert K. Orr, Jr, DO, chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing (shown standing at far right).

A luncheon for members of the MSMS Committee on Concerns of Women Physicians was one of several special events held during the MSMS Annual Scientific Meeting in Dearborn. Shown standing is MSMS President Susan H. Adelman, MD.

A reporter from WWJ Radio, Detroit, took a moment to interview Vernon N. Houk, MD, who spoke on "Caring for the Environment" at the Thursday morning "early bird" plenary session. Doctor Houk is assistant surgeon general, director, Center for Environmental Health, Centers for Disease Control, Atlanta.

PHOTOS BY:
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Gennara
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MSMS
ANNUAL SCIENTIFIC MEETING

HIGHLIGHTS

State agency heads call for physician input on environment's health effects

By Claudia Skutar

Input from physicians is needed in solving environmental problems and protecting public health, according to government agency officials who spoke to physicians at the MSMS Annual Scientific Meeting, November 6-8, 1990, in Dearborn.

"Physicians have a tradition as community leaders," said Vernon Houk, MD, MPH, director of the Center for Environmental Health of the Atlanta Centers for Disease Control. "On (environmental) issues, it's very important for physicians to become knowledgeable so they can provide information to their communities and their patients."

Doctor Houk was one of five panelists who addressed nearly 100 physicians at the November 8 half-day session on the environment. The panel, moderated by Kenneth Rowe, MD, MSMS representative to the state's Council on Environmental Quality, talked about environmental problems and the need to better inform the public as a way to protect public health.

"The public health movement in the United States began on an environmental issue," said Doctor Houk. "Our colleagues of 150 years ago collected data for sound planning and made a concerted effort for nearly 30 years, and effectively provided for safe drinking water."

However, Raj M. Weiner, former director of the Michigan Department of Public Health (MDPH), while agreeing that the public needs more information on environmental problems, said the way in which information is presented is important, too.

"We can't scare people," she said. "We must give them information that is useful and will help them."

Weiner outlined some of the successes that MDPH has had in its environmental programs, noting that the department plans to expand its programs in the future. She said two specific areas, fish contaminants and radon, have become important issues.

"A lack of information to the public is contributing to a lack of anything being done (in these areas)," said Weiner. She asked for physician help in distributing information on the dangers of these two problems. "The credibility that physicians can bring to environmental issues can make a difference," Weiner said. "I certainly see our community of physicians at the forefront of environmental protection ...nobody speaks with more authority on environmental health than physicians."

Weiner also said that efforts to prevent release of chemical contaminants in the Great Lakes have had mixed results.

"The good news is that contaminant levels are down in the lakes, but the bad news is that those levels still may be too high for the most sensitive among us," she said.

Unfortunately, the environment can't be restored to its pristine condition because there aren't the technological or financial resources to do that," said Lynelle Marolf, assistant to the Michigan Department of Natural Resources (DNR) Deputy Director of Environmental Protection. Current cost estimates for cleanup of the state's more than 2,800 identified chemical contamination sites are four to eight billion dollars, according to Marolf.

"We'd like to restore the sites to what they were but we can't because of the tremendous strain on our financial resources," she said.

Recognition of this fact was one factor that led the DNR to shift to risk-based decisionmaking rather than making decisions based on a requirement to restore the environment to a pristine condition, Marolf said.

"One of the strengths of risk assessment is that it allows us to make judgments about the wise use of resources," Marolf said. "Risk assessment in regulatory programs...helps us to understand the likelihood of harm."

Doctor Houk noted that risk assessment is a process which should be used with a great deal of common sense and scientific judgment.

"Risk assessment should present a range to policymakers so that rational decisions can be made," he said.

Protecting human health does not fall to just the MDPH and the DNR alone. One of the functions of the Michigan Department of Agriculture (MDA) is to protect human health by monitoring the state's food supply. The department's chief deputy director, Bruce D. Cardwell, PhD, outlined for physicians the functions of the MDA and how it works to protect people from contaminants that may enter the food chain.

For instance, the department's Pesticide and Plant Pest Management Division administers the Pesticide Control Act, according to Cardwell. Through monitoring and other means the MDA division attempts to prevent pesticides from entering the food chain.

"In cases where misapplication of pesticides occurs, we can impose civil and criminal penalties," Cardwell said.

Despite strong efforts by the MDA, the MDPH, and the DNR to inform the public and protect against environmental threats to human health, there is one environmental hazard whose health effects are little understood by the public. Doctor Houk noted that radon gas leakage into homes converts the risk of lung cancer for a nonsmoker to that of a smoker.

"Testing a house for radon should be done for the health of a consumer just as a termite test is done (on a house) for the protection of a financial institution (making a loan on the house)," said Doctor Houk.

Mark J. Upfal, MD, assistant professor of the Department of Family Practice and Division of Occupational and Environmental Medicine, Wayne State University School of Medicine, outlined the serious and underestimated threat that radon poses to human health.

"Risk estimates attribute between 5,000 and 20,000 lung cancer deaths per year from radon," said Doctor Upfal. "Even if those estimates are wrong, it is still very easy to mitigate these deaths through preventative measures."

These preventative measures are cost effective and available through current technology, he noted. One of the most important ways to mitigate the effects of radon is to stop smoking, he said. Accord-

Continued on next page

UPFAL
ROWE
MAROLF

Six speakers were featured at the Thursday morning session on "Caring for the Environment." Shown above are (l to r): Mark J. Upfal, MD, assistant professor, Department of Family Practice and Division of Occupational and Environmental Medicine, Wayne State University School of Medicine; Kenneth Rowe, MD, MSMS representative to the Council on Environmental Quality; Lynelle Marolf, assistant to Deputy Director of Environmental Protection; Burton D. Cardwell, PhD, chief deputy director, Michigan Department of Agriculture; Susan H. Adelman, MD, MSMS president; and Raj M. Weiner, director, Michigan Department of Public Health (at podium).

ing to a June 1990 radon toxicity report produced by the US Department of Health and Human Services and authored, in part, by Doctor Upfal, it is likely that there is a synergy between the interaction of smoking and radon exposure.

"A smoker's risk of radon-induced lung cancer is 10 to 20 percent higher than a nonsmoker's risk," Doctor Upfal said.

Radon is a radioactive, colorless, odorless gas which comes from the natural breakdown of uranium. It was discovered in the early 1900s through mining studies, but only much later was it clinically recognized as a carcinogen, according to Doctor Upfal. High natural concentrations of radon can be found in the soil, and also in soils contaminated with certain types of industrial wastes. Radon also is present in the air, but usually only in such diluted concentrations that it isn't harmful. It becomes harmful whjen it accumulates in an enclosed space, such as a basement. The gas, which can move through small spaces in the soil and rock on which a house is built, can enter a home through dirt floors, cracks in concrete floors and walls, floor drains, and sumps. Particulates in the gas are inhaled and trapped in the lungs. As they decay, they release small bursts of energy in the lung tissue. Currently, the only known health effect of elevated exposure to radon is an increased risk of lung cancer.

The risk of lung cancer at some levels of radon exposure may be greater than the risks of myocardial infarction or auto accidents, Doctor Upfal said.

"The risk is underestimated by the public," Doctor Upfal said. "The only preventative measures are detection and mitigation. There is no diagnosis and treatment that significantly prevents lung cancer."

Doctor Houk noted that "as a country we're concerned about man-made carcinogens, but not natural carcinogens." Still, with the proliferation of the development and use of toxic chemicals in manufacturing, agriculture and even in daily life, Doctor Houk feels that toxic chemicals are an environmental and health concern as well.

"Most substances considered toxic to humans by the public are man-made chemicals," he said. "The greatest waste sites waiting to be disposed of are in our garages or under our sinks, and we tend to dispose of things by dumping them down the drain."

Agricultural chemicals are important economic commodities, he noted, but said that there is good evidence that about four times what is necessary is being used. "The only way (use of these chemicals) will be controlled is to make it economically infeasible to use more than necessary," he said.

Doctor Houk said his major concern about chemicals is in unplanned releases of them into the environment. Echoing a theme he developed during a one-hour environmental plenary session preceding the half-day panel presentation, Doctor Houk said preparations must be made to mitigate the chances of that happening.

"Emergency contingency planning is another central element that we as physicians must be involved in during the next century," Doctor Houk said. "It is not being done now."

Hazards often result in disasters due to lack of planning, Doctor Houk said and "physicians must be prepared to deal with these hazards."

"Decisions on the environment will be made, and unless physicians are involved, they won't be made on sound public health principles," he said. ■

Claudia Skutar is communications specialist for MSMS.

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MSMS MEDICAL JOURNAL

QUIZ ABOUT MSMS JOURNAL

1. Name the AMA president who is a former scientific editor of *Michigan Medicine*.

2. Name the editor who served the longest, from 1942-63.

3. Who was the last scientific editor?

4. When did MSMS publish its first issue of its journal, now known as *Michigan Medicine*?

By Herb Auer

Michigan medical historians generally agree that the history of medical journalism in Michigan dates back to July 1853 when the Peninsular Journal of Medicine and Collateral Sciences *was published in Ann Arbor by Edmund Andrews, MD, and printed by the George E. Pomeroy and Company in Detroit. In 1855, Doctor Zina Pitcher and others moved the publication to Detroit and it ceased publication in 1856.*

There were many other attempts by physicians to publish a medical journal and often there was more than one at the same time competing for advertising and subscriptions. Mentioned in early Michigan medical history, for example, are the Medical Independent, *the* Detroit Review of Medicine and Pharmacy, *the* Detroit Medical Review. *There also was the* Detroit Lancet, Michigan Medical News, Medical Age, Detroit Homeopathic College Bulletin, *the* Physician and Surgeon *and many more. (The long list of these early publications is featured in the* Medical History of Medicine, *Vol. I, pp. 645-647.*

The University of Michigan Medical School began its first attempt with a medical journal in March 1870; that lasted three years.

The Burr publication blames the failures of many on poor business management, infrequent publication, and "some were merely promotional for publishing houses or medical philosophies."

"We say that a first-class doctor is a member of the AMA, MSMS and the local medical society," declared an editorial on July 25, 1878, in the third volume of the *Michigan Medical News*, which was more supportive of medical society goals than others.

For a period of years beginning with January 1878, there was a twice-a-month *Michigan Medical News*. With eight co-editors and J.J. Mulheron, MD, Detroit as the managing editor, the publications ran 24 pages, with circulation reported at 2,000 and usually 8-12 full pages of advertising. The subscription cost was one dollar and names of new subscribers were published in each issue. The ads proclaimed Extract of Malt, Bromo-Chloralum, Turkish Baths, Pepsin, Cod Liver Oil and Iodide of Iron. Other ads promoted the services and conferences at the University of Michigan and other medical schools.

During the period before MSMS created its own journal, MSMS published 500-page books of *Transactions of the Michigan State Medical Society* each year. (I have a copy of the 1901 issue when A. P. Biddle, MD, Detroit, was editor, and also 1902 when Charles W. Hitchcock, MD, Detroit, was editor.) Those volumes contained the address of the MSMS president, papers and discussions, and complete transcript of the annual meeting.

The first issue of the MSMS journal was in September 1902, with $2,500 in advertising income.

Continued on next page

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Continued from previous page

The moving force had been Leartus Conner, MD, president in 1902, when a committee of four physicians were directed "to issue transcripts in the form of a monthly journal to be known as the journal of the state society," according to Doctor Burr. Doctor Conner had first suggested in 1896 that the state society begin its own publication. Prior to that, medical society news might appear in any of the many short-lived publications, coming from different points of view.

During the early years of the MSMS journal, the society secretary was also the editor. The first editor was A. P. Biddle, MD, for Vol. I, II, III, and IV. Doctor Biddle also served two terms later as the state president (1916-1918). Records show that Doctor Haughey, while a young doctor recently graduated from medical school, edited Vol. IX, X and XI.

The longest serving editor and society secretary during that period was F.C. Warnshuis, MD, of Grand Rapids, who served for 16 years (1913-1929).

It was in 1928 that the MSMS Council voted to divide the duties of the secretary and the editor. The first scientific editor was J. H. Dempster, MD, with Doctor Warnshuis as manager. All of this was long before MSMS selected its first full-time executive, William J. Burns, in 1935. He served through 1963.

During the period 1950-70, the Michigan journal was highly regarded by AMA officers, science writers and other state journal editors for its scientific content. Often during that period, the Michigan journal was acclaimed "the best" at AMA publications conferences.

Changes in the content and design of the publication included a name change from the *Journal of the Michigan State Medical Society* to *Michigan Medicine.* One reason for the change was that physicians then received so many publications called "Journal." Another example of a name change was from the *Journal of the American Medical Association* to *JAMA.*

The longest-serving recent scientific editor was Wilfred Henry Haughey, MD, Battle Creek, who served from 1942 to his death in 1963. He was followed by C.J. Tupper, MD, Ann Arbor. The last scientific editor was John W. Moses, MD, Detroit.

Society responsibility for the journal rests with the MSMS Committee on Publications. At each meeting, committee members review plans and offer the editor guidance. That body in September 1965 voted to change from the Bruce Publishing Company in St. Paul to a Lansing Printer, Wellman Press, which continued until September 1989. The current printer is Pendell Printing, Inc., Midland.

Attractive cover designs for a period of 10-15 years were created by Dirk Gringhuis, an MSU and East Lansing artist. Bob Brent, also an MSU and East Lansing artist, has designed the covers since January 1989.

I was elevated to managing editor of *Michigan Medicine* in the summer of 1963. In that capacity, I drew from experiences as an art teacher, publications designer and editor at MSU, and as a freelance graphics designer to sharpen the journal's appearance.

Judy Marr, now manager of the MSMS Department of Communications, joined MSMS in 1968 as managing editor (I then served as executive editor). She had been with the *Lansing State Journal.*

In 1979, when I became the CEO of the Michigan Health Council, Marr stepped up to editor — a position she held until January 1990 when she was elevated to department head. Betty McNerney, who joined the MSMS staff in 1987 as managing editor, then became the editor — a post she still holds.

Journals designed and edited by me, Marr and McNerney have received national first place honors several times from Sandoz Pharmaceuticals. ■

Herb Auer had been associated with Michigan Medicine for 20 years before leaving MSMS for The Michigan Health Council in 1979.

Historic material in this article was obtained primarily from the two-volume Medical History of Michigan, *published by MSMS in 1930 and edited by L.R. Burr, MD, Flint, chairperson of a five-man committee appointed to that writing task in 1926. Doctor Burr wrote most of the articles. In the first volume there were contributions by eight Michigan physicians in the 829-page publication, and the second volume ran 940 pages with articles by six others. Vol. II contains a 57-page index for the two books.*

Historical information also came from the 54-page A Century of Service in Michigan *published by MSMS as a highlight of the MSMS 100th year in 1966.*

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The individuals listed at right are a very integral part of the Michigan State Medical Society – they are the staff. The 65 members of the staff provide a wealth of information and assistance every day to MSMS members who have questions and want answers.

Here are just a few of the questions MSMS has received and answered: "Medicare has not sent a payment in three months and I have provided over $60,000 worth of treatment. Who can I talk to at BCBSM about this problem?" "I neglected to renew my license and I am scheduled for surgery tomorrow. I cannot reach the Department of Licensing and Regulation. Can you help me?" Staff was able to provide assistance to these physicians and stands ready to assist the membership everyday.

Do not forget that the MSMS staff members listed at right can help you through a bureaucratic maze, give you the most complete information about the current health care delivery system, or simply provide you with directions to the MSMS building. If you have questions, we encourage you to pick up the phone and call us.

Address changes	Peg Berry
Advertising (in *Michigan Medicine)*	Betty McNerney
AIDS Provider Education Project	Bonnie McCauley
AMA Delegation	Judy Marr
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Dan Farhat
Auto Lease Plan	Richard Campau
Blue Cross Blue Shield/Third Party Payors	Mary Anne Ford
Board of Medicine	Dan Farhat, Tom Wolff
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (in *Michigan Medicine)*	Sherry Fent
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Federal Legislation	Kevin Kelly
Financial Operations	Richard Campau
Graduate Medical Education	Sherry Fent
Group Health Insurance Plan	Barb Zimmerman, Valerie Barker
Health Data Research	Julie Lester
Health Education Foundation	Vada Davis
HMOs/PPOs	Mary Anne Ford
Hospital Medical Staff Relations	Tom Plasman
Judicial Commission	Katie Brewbaker
Legislation	Dan Farhat, Tom Wolff
Maternal Health Conference	Sherry Fent
Media Relations	David Fox
Medicaid	Dan Farhat, Tom Wolff
Medical Assistants	Caroline Kimmel
Medical Ethics	Katie Brewbaker
Medicare	Rose Heald
Medigram	Betty McNerney, Claudia Skutar
Member Benefits (including insurance programs)	Richard Campau
Membership Records	Peg Berry
Membership Recruitment	Deborah Zannoth
Michigan Allergy Society	Viola Heins
Michigan Association of Medical Education	Viola Heins
Michigan Dermatological Society	Dawn Reha
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medical Group Managers Association	Caroline Kimmel
Michigan Medicine (MSMS Journal)	Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
Michigan Society of Internal Medicine	Caroline Kimmel
Michigan Society of General Surgeons	Caroline Kimmel
Michigan Society of Pathologists	Viola Heins
Michigan Society of Respiratory Therapy	Caroline Kimmel
MSMS Auxiliary	Viola Heins
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	Richard Campau, Donna Farougi
MSMS Meeting Facilities	Lori Randall
MSMS Travel Programs	Donna Farougi
Physicians Communication Network	Katie Brewbaker
Physicians Recovery Network	Katie Brewbaker
Peer Review Organization of Michigan, Inc. (PROM)	John Richards, Barbara Banks, RN
Physician Legislative Network	Dan Farhat, Tom Wolff
Physician Service Group, Inc.	John Richards
Seminars	Amy Fistler
Practice Management	John Richards, Amy Fistler
Professional Liability Insurance	Tom Wolff
Public Health Liaison	Dan Farhat, Tom Wolff
Public Relations	Judy Marr
Risk Management	Julia Smith
Specialty Societies	Donna Farougi

A Closer Look at MSMS' Health Insurance Program

By Valerie Barker

Created in 1987, Michigan State Medical Society's (MSMS) Group Insurance Trust assumed responsibility for the administration of physician's Blue Cross Blue Shield of Michigan (BCBSM) health insurance. Providing personalized service for physicians, their families and their employees was and still is the main purpose for establishing the MSMS Group Insurance Trust. MSMS Group Insurance trustees work on behalf of member physicians and are committed to providing access to affordable, multi-faceted health insurance coverage, backed by a stable insuring company, which allows physicians to choose health care coverage best suited to their needs. MSMS Group Insurance Trustees include B. David Wilson, MD, who acts as chairman; Jack Barry, MD, Billy Ben Baumann, MD, Henry M. Domzalski, MD, Robert E. Paxton, MD, W. Peter McCabe, MD, Earl G. Moehn, MD, and William E. Madigan, MSMS executive director. Physician Service Group, Inc., a member service subsidiary of MSMS, through a contract with the Group Insurance Trust, provides personalized service to the more than 6,000 BCBSM subscribers.

In response to physicians needs, the Group Insurance Trust has conducted member surveys and studies of health care coverages and insurance companies. The results of those surveys and studies reinforced the trustee's decision to continue offering BCBSM coverage. In these studies, members continually indicate access is very important. National statistics indicate some 37 million Americans have no health insurance. Being able to offer coverage to everyone, regardless of age, gender or previous medical history is the foundation of an association-sponsored program whose membership is extremely diverse.

A look at the options

Following recommendations, which were the result of extensive studies done by Health Decisions, Inc., Livonia, Michigan, the trustees elected to redesign the BCBSM options offered. Effective March 1, 1990, two plans, one for physicians, one for employees, introduced three choices — a "First Dollar" hospital/medical/surgical option and two comprehensive options, each with a different deductible. With the introduction of the Comprehensive Major Medical options, physician's now have more choices when selecting health coverage. By sharing some first dollar health care costs, the Comprehensive Major Medical options provide excellent hospital/medical/surgical coverage combined with lower premiums. Special provisions allow for family continuation. Should the member subscriber die while insured through the program, his/her family can continue to participate in the MSMS program.. No other Blue Cross Blue Shield plan offers this special provision. For physicians 65 years of age or older, a Complementary "Exact Fill" (to Medicare) program is availabe. This option provides the same level benefits (basic and Master Medical) payable under the "First Dollar" plan, less any benefits payable by Medicare. A similar Medicare Complementary program is available to employees. Additionally, a free-standing prescription drug program was also introduced. This $5 co-pay program is available to physicians and employees and can be added to any option. Previously, only those choosing the "First Dollar" option had prescription drug coverage and then it was subject to applicable deductibles and co-payments.

During the March 1990 "Open Enrollment," 763 subscribers chose the new prescription drug coverage. Records indicated approximately 1,300 requests for option changes were processed during this latest open enrollment, with 26 percent of the subscribers choosing a Comprehensive Major Medical option. However, "First Dollar" coverage continues to be the option of choice for the majority of the 6,000-plus subscribers covered by the program.

A detailed description of the member and employee options appears on pages 34 and 35 respectively.

Interest in program growing

Growing interests in the MSMS health insurance program is evident by the number of telephone inquiries received. Staffed by three highly-trained service representatives, those who call the Group Insurance Trust can talk with Kathy Hagen, Jane Walworth or Cari Ambrose. Using their expertise, Kathy, Jane or Cari can quickly explain the various options available to members and employees. They are also helpful when subscribers need assistance. Subscribers prefer talking with someone familiar with their situation. "On average, the Group Insurance Trust receives over 800 telephone calls a month," says Barbara Zimmerman, chief of insurance operations, MSMS Group Insurance Trust. Supported by a new telephone system and a national toll-free telephone number, service representatives handle a wide variety of inquiries. Those inquiries include explanation of benefits; subscriber eligibility; insurance rates; billing questions; membership changes; and claims assistance. With this personalized service, subscribers almost never need to contact BCBSM directly.

Trustees of the MSMS Group Insurance Trust continue working toward program improvements and expanded personalized service. Some new services will be available early in 1991. The first involves expanded computer and software systems, which will improve existing invoicing capabilities. Currently, subscribers receive an individualized bill every other month, mailed to their home or workplace. The new system will allow for a "group type" bill. With the new system, physicians offices can receive a single invoice listing premiums for themselves and all their employees, instead of the multiple bills now received. The second features the availability of "true-group" coverage. Currently, the coverage offered is "individual" and does not require a minimum number of participants be enrolled to be eligible for the coverage. The group options, similar to the current individual options in coverage and cost, are designed for the larger medical practice which needs a "true-group" program.

To learn more about your association-sponsored BCBSM insurance program and to sample personalized service, call the MSMS Group Insurance Trust at 1-800-748-0195. Service representatives are available to take your call.

As chief of insurance marketing for the MSMS Group Insurance Trust, I am available to meet with member physicians and/or employees to explain in detail the benefits of the MSMS health insurance program. I look forward to hearing from you. ■

Valerie Barker is chief of insurance marketing for the MSMS Group Insurance Trust.

Michigan State Medical Society *MEMBER*

BENEFITS	TRADITIONAL WITH MASTER MEDICAL OPTION 1	COMPREHENSIVE MAJOR MEDICAL (CMM) OPTION 2/
Inpatient Hospital Care		
General conditions (Semi-private room, meals, special diets, general nursing care, intensive care units, drugs, equipment and supplies, etc.)	365 days, 60-day renewal; additional days under MM; no deductible/copays	Unlimited days; 80% after deductible
Pulmonary TB	45 days; 60-day renewal; additional days under MM; no deductible/copays	Unlimited days; 80% after deductible
Outpatient Hospital Care *(Emergency Care)*		
Accidental	Covered	80% after deductible
Medical Emergencies (Life-threatening)	Covered	80% after deductible
Physical Therapy	60 consecutive days, per calendar year; additional days under MM; 80% after deductible	Unlimited treatment; 80% after deductible
Mental Health Care		
Inpatient Psychiatric Care (Approved Facilities)	45 days; 60-day renewal; additional MM benefits at 50% after deductible up to psychiatric maximum	50% after deductible, up to psychiatric maximum
Residential Substance Abuse Care (Approved Facilities)	Unused mental health care days (No MM coverage)	50% after deductible, up to psychiatric maximum
Outpatient Psychiatric Care (Services performed by a Psychologist are excluded unless billed/supervised by a Psychiatrist)	50% after deductible, up to psychiatric maximum	50% after deductible, up to psychiatric maximum
Outpatient and Non-hospital Residential Substance Abuse Care	Covered up to annual maximum set by state	50% after deductible, up to annual maximum set by state
Special Programs		
Hospice Care	Coverage limited to a lifetime maximum of $6,884. Professional services are limited to $650 per member per lifetime	Coverage limited to a lifetime facility maximum of $6,884. Professional services are limited to $650 per member per lifetime
Convalescent Care	Twice the number of unused general days; 60-day renewal	Not covered
Specified Human Organ Transplant (Approved facility)	Covered (Subject to 9 consecutive months waiting period)	Covered (Subject to 9 consecutive months waiting period)
Medical/Surgical Care		
Surgery/Technical/Surgical Assistance/Anesthesia	Covered	80% after deductible
Obstetrical Delivery	Covered	80% after deductible
Chemothrerapy	Covered	80% after deductible
Laboratory and Pathology	Covered	80% after deductible
Inpatient Medical Care	General-unlimited days; Pulmonary TB-45 days; Nervous/Mental-45 days	General and Pulmonary TB-Unlimited days; 80% after deductible. Nervous/Mental-50% after deductible up to psychiatric care maximum
Inpatient Consultations	Covered	80% after deductible
Diagnostic Services (EKGs, EEGs, etc.)	Covered	80% after deductible
Diagnostic and Therapeutic Radiology	Covered	80% after deductible
Emergency Care Accidental and Medical (Life-Threatening)	Covered	80% after deductible
Office Visits	80% under MM after deductible	80% after deductible
Pre- and Post-Natal Care	Covered	80% after deductible
Allergy Testing/Therapy	80% under MM after deductible	80% after deductible
Ambulance	80% under MM after deductible	80% after deductible
Private Duty Nursing	50% under MM after deductible	50% after deductible
Prosthetic and Orthotic Appliance	80% under MM after deductible	80% after deductible
Prescription Drugs	80% under MM after deductible (if optional Prescription Drug Program not selected)	Not covered
Prescription Drug Program *(optional)*	$5 Copay	$5 Copay
Deductibles, Copayments, and Benefit Maximums	**Basic:** No deductible/copayments as noted **Master Medical:** Deductible: $150 per person, $300 per family each calendar year **Copayments:** 20% General services (Out-of-Pocket maximum, $1,000 per calendar year), 50% mental health and private duty nursing **Maximums:** $1 million per member lifetime **All Psychiatric Care:** $15,000 per member, per year, $30,000 per member, per lifetime **Outpatient:** $2,000 per member, per year, $5,000 per member, per lifetime Additional $1 million maximum per covered specified human organ transplant (no deductible/no copay)	**Option 2:** Deductible: $500 per person, $1,000 family **Option 3:** $1,500 per person, $3,000 per family each calendar year **Copayments:** 20% General services (Out-of-Pocket maximum, $1,000 per calendar year), 50% mental health care and private duty nursing **Maximums:** $1 million per member lifetime **All Psychiatric Care:** $15,000 per member, per year, $30,000 per member, lifetime **Outpatient:** $2,000 per member, per year, $5,000 per member, lifetime Additional $1 million maximum per covered specified human organ transplant (no deductible/no copay)
Payment of Benefits	**Participating Hospitals:** 100% of covered benefits, less applicable deductible and/or copays **Nonparticipating Hospitals:** Inpatient care in acute-care hospitals: $70 a day, less applicable deductibles and/or copays. Inpatient care in other hospitals; $15 a day, less applicable deductibles and/or copays. **Outpatient Care:** $25 per covered condition, less applicable deductible and/or copays **Medical/Surgical Care:** 100% of BCBSM's reasonable charge, less applicable deductible and/or copays.	

This is intended as an easy to read guide. It is not a contract. An official description of benefits are contained in applicable Blue Cross and Blue Shield of Michigan Certificates and riders. This coverage is provided pursuant to a contract entered into This coverage is provided pursuant to a contract entered into the State of Michigan and shall be construed according to the laws of the State of Michigan.

Michigan State Medical Society

BENEFITS	TRADITIONAL WITH MASTER MEDICAL OPTION 1	COMPREHENSIVE MAJOR MEDICAL (CMM) OPTION 2/3
Inpatient Hospital Care		
General conditions (Semi-private room, meals, special diets, general nursing care, intensive care units, drugs, equipment and supplies, etc.)	365 days, 60-day renewal; additional days under MM; no deductible/copays	Unlimited days; 80% after deductible
Pulmonary TB	45 days; 60-day renewal; additional days under MM; no deductible/copays	Unlimited days; 80% after deductible
Outpatient Hospital Care *(Emergency Care)*		
Accidental	Covered	80% after deductible
Medical Emergencies (Life-threatening)	Covered	80% after deductible
Physical Therapy	60 consecutive days, per calendar year; additional days under MM; 80% after deductible	Unlimited treatment; 80% after deductible
Mental Health Care		
Inpatient Psychiatric Care (Approved Facilities)	45 days; 60-day renewal; additional MM benefits at 50% after deductible up to psychiatric maximum	50% after deductible, up to psychiatric maximum
Residential Substance Abuse Care (Approved Facilities)	Unused mental health care days (No MM coverage)	50% after deductible, up to psychiatric maximum
Outpatient Psychiatric Care (Services performed by a Psychologist are exculded unless billed/supervised by a Psychiatrist)	50% after deductible, up to psychiatric maximum	50% after deductible, up to psychiatric maximum
Outpatient and Non-hospital Residential Substance Abuse Care	Covered up to annual maximum set by state	50% after deductible, up to annual maximum set by state
Special Programs		
Hospice Care	Coverage limited to a lifetime maximum of $6,884. Professional services are limited to $650 per member per lifetime	Coverage limited to a lifetime facility maximum of $6,884. Professional services are limited to $650 per member per lifetime
Specified Human Organ Transplant (Approved facility)	Covered (Subject to 9 consecutive months waiting period)	Covered (Subject to 9 consecutive months waiting period)
Medical/Surgical Care		
Surgery/Technical/Surgical Assistance/Anesthesia	Covered	80% after deductible
Obstetrical Delivery	Covered	80% after deductible
Chemotherapy	Covered	80% after deductible
Laboratory and Pathology	Covered	80% after deductible
Inpatient Medical Care	General-unlimited days; Pulmonary-45 days; Nervous/Mental-45 days	General and Pulmonary TB-Unlimited days; 80% after deductible. Nervous/Mental-50% after deductible up to psychiatric care maximum
Inpatient Consultations	Covered	80% after deductible
Diagnostic Services (EKGs, EEGs, etc.)	Covered	80% after deductible
Diagnostic and Therapeutic Radiology	Covered	80% after deductible
Emergency Care (Physician) Accidental and Medical (Life-Threatening)	$15 per admission 80% under MM after deductible	80% after deductible 80% after deductible
Office Visits	80% under MM after deductible	80% after deductible
Pre- and Post-Natal Care	80% under MM after deductible	80% after deductible
Allergy Testing/Therapy	80% under MM after deductible	80% after deductible
Ambulance	80% under MM after deductible	80% after deductible
Private Duty Nursing	50% under MM after deductible	50% after deductible
Prosthetic and Orthotic Appliance	80% under MM after deductible	80% after deductible
Prescription Drugs	80% under MM after deductible (if optional Prescription Drug Program not selected)	Not covered
Prescription Drug Program *(optional)*	$5 Copay	$5 Copay
Waiting Periods	For all of the above options, members must be enrolled for 180 days before benefits are available for the removal of tonsils and adenoids for dependents under age 19; and for pre-existing conditions. There is a 270 day waiting period for maternity/obstetrical benefits and specified human organ transplant benefits.	
Deductibles, Copayments, and Benefit Maximums	**Basic:** No deductible/copayments as noted **Master Medical:** Deductible: $150 per person, $300 per family each calendar year **Copayments:** 20% General services (Out-of-Pocket maximum, $1,000 per calendar year), 50% mental health and private duty nursing **Maximums:** $1 million per member lifetime **All Psychiatric Care:** $15,000 per member, per year, $30,000 per member, per lifetime **Outpatient:** $2,000 per membr, per year, $5,000 per member, per lifetime Additional $1 million maximum per covered specified human organ transplant (no deductible/no copay)	**Option 2:** Deductible: $250 per person, $500 for the family **Option 3:** $1,000 per person, $2,000 per family each calendar year **Copayments:** 20% General services (Out-of-Pocket maximum, $1,000 per calendar year), 50% mental health care and private duty nursing **Maximums:** $1 million per member lifetime **All Psychiatric Care:** $15,000 per member, per year, $30,000 per member, lifetime **Outpatient:** $2,000 per member, per year, $5,000 per member, lifetime Additional $1 million maximum per covered specified human organ transplant (no deductible/no copay)
Payment of Benefits	**Participating Hospitals:** 100% of covered benefits, less applicable deductible and/or copays **Nonparticipating Hospitals:** Inpatient care in acute-care hospitals: $70 a day, less applicable deductibles and/or copays. Inpatient care in other hospitals; $15 a day, less applicable deductibles and/or copays. **Outpatient Care:** $25 per covered condition, less applicable deductible and/or copays **Medical/Surgical Care:** 100% of BCBSM's reasonable charge, less applicable deductible and/or copays.	

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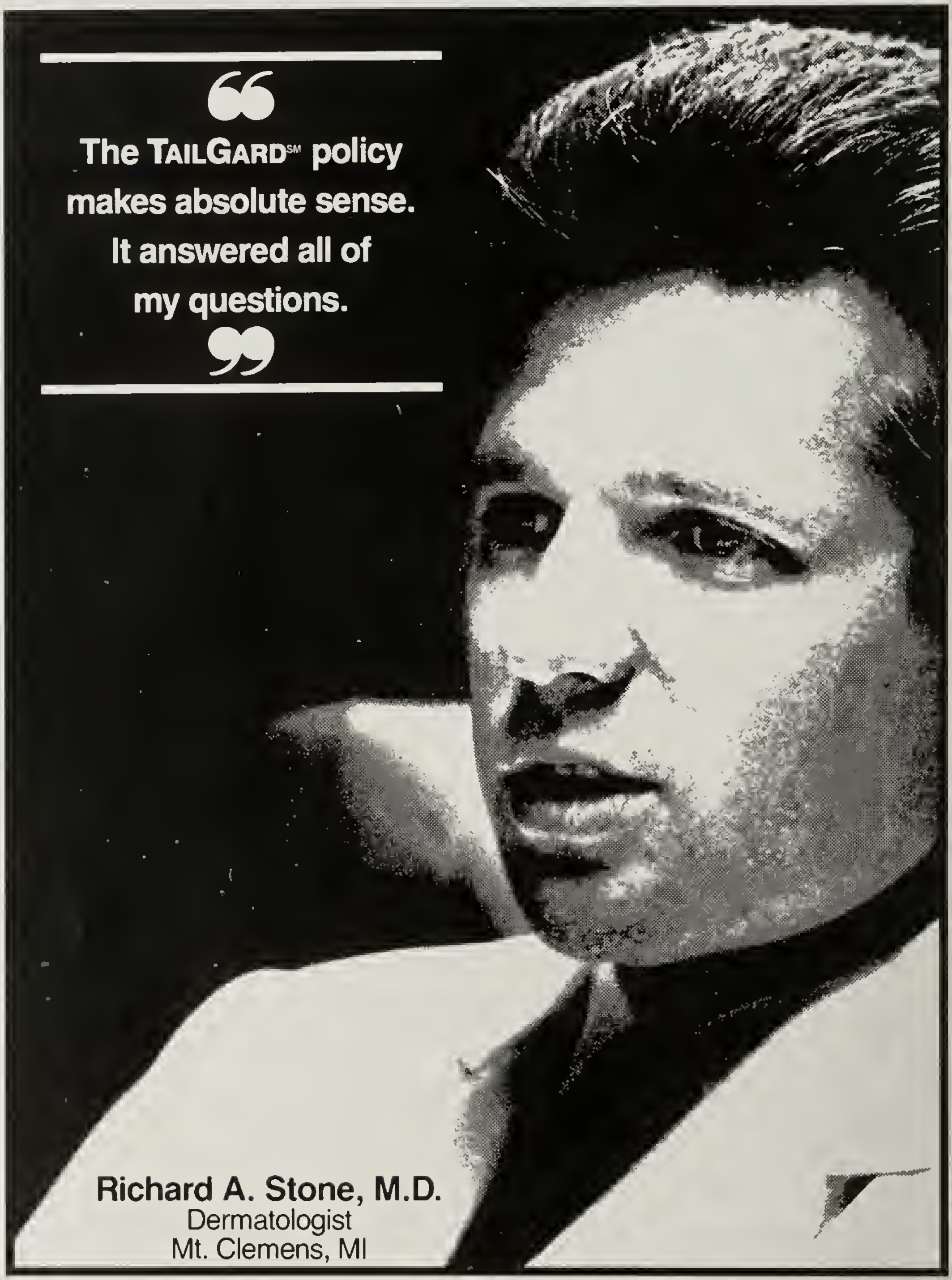
TIMES·HAVE·CHANGED



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Richard A. Stone, M.D.
Dermatologist
Mt. Clemens, MI

“PHYSICIANS in the past practiced in one location throughout their careers. Today's environment in medicine is totally different.

Many young physicians move their practices. With claims-made, they may have to come up with a large volume of cash to buy tail coverage. That's a major stumbling block to moving.

The **TailGard℠** policy, Michigan Physicians' claims-made coverage with a built-in tail, makes absolute sense. It answered all of my questions. If I decided to move, I could do so without the stumbling blocks of claims-made. And I could save on my premium at the same time.

TailGard℠ coverage offers a substantial rate reduction. I can look at the bottom line and see savings.

Times have changed, and Michigan Physicians deserves credit for answering our problems and questions. They're a good group of people who are always responsive to me.

In a competitive environment, it's unique for anyone to have a positive impact. But Michigan Physicians has done it.”

Michigan Physicians
mutual liability company

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Steven K. Campbell, MD, 173-E Chicago, Coldwater, MI 49036
Action, Date Taken: Revoked; December 17, 1990
Reason: Fraud in obtaining a license

Name: Linda K. Cross, MD, 15217 W. Michigan Ave., Marshall, MI 49068
Action, Date Taken: Summarily suspended; November 14, 1990
Reason: Drug related

Name: Vincent T. Guarnaccia, MD, 2827 E. Saginaw, Lansing, MI 48912
Action, Date Taken: Fined - $1,500; November 16, 1990
Reason: Technical violation

Name: Larry L. Kompus, MD, 4166 Stoddard, Orchard Lake, MI 48033
Action, Date Taken: License Surrendered voluntarily; October 12, 1990
Reason: Negligence, incompetency

Name: Lawrence S. Lackey, MD, Tri-City Medical Center, 310 Visger Rd., River Rouge, MI 48218
Action, Date Taken: Summary suspension; September 19, 1990
Reason: Negligence - Incompetency

Name: William L. McPhail, MD, 22461 Trojan, Detroit, MI 48219
Action, Date Taken: Revoked, Fined - $15,000; November 15, 1990
Reason: Drug related

Name: David Anthony Vila, MD, 3989 Rosewood Ave., Los Angeles, CA
Action, Date Taken: Suspended, six months and one day; December 17, 1989
Reason: Negligence - Incompetency

Name: Henry J. Winkler, MD, 9139 Cadieux, Detroit, MI 48224
Action, Date Taken: Summary suspension; September 19, 1990
Reason: Drug related

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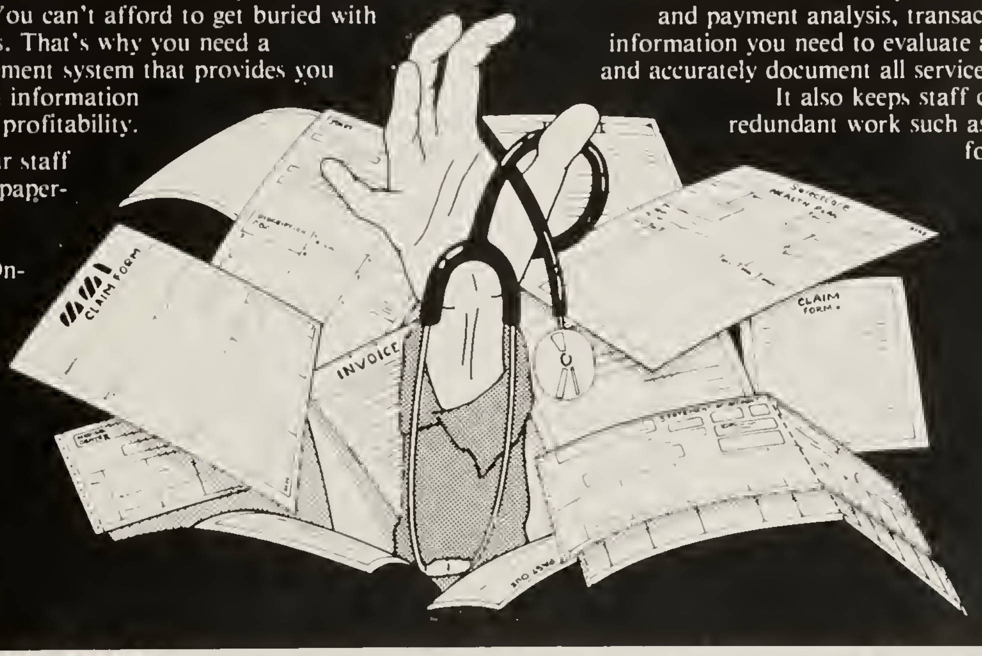

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Michigan State Medical Society

in cooperation with its subsidiary

Physician Service Group, Inc.

announces its

1991 Seminar Schedule

Better Billing/Reception Patient Flow
February 5 .... Detroit
February 6 .... Lansing
February 7 .... Grand Rapids

Conomikes Medicare Update
February 12 .... Detroit
February 13 .... Bay City
February 14 .... Kalamazoo

Advanced Coding
February 19 .... Bay City
February 20 .... Ann Arbor
February 21 .... Kalamazoo

ICD-9
March 5 .... Detroit
March 6 .... Bay City
March 7 .... Lansing
October 8 .... Traverse City
October 9 .... Grand Rapids
October 10 .... Detroit

How to Improve Patient Services
March 13 .... Detroit
March 14 .... Grand Rapids

IC Collections
March 20 .... Detroit
March 21 .... Grand Rapids

MSMS/BCBS Medicare
April 9 .... Marquette
April 10 .... Grand Rapids
April 11 .... Detroit

How to Run a More Profitable Practice
April 16 .... Kalamazoo
April 17 .... Bay City
April 18 .... Detroit

Supervising and Managing Office Staff
April 23 .... Detroit

Working With People
April 24 .... Detroit

Estate Planning - $^1/_2$ day
April 24 .... Detroit

Financial Planning
May 9 .... Ann Arbor

Health Law Update
May 9 .... Ann Arbor

Starting Yourself in Medical Practice
June 7-8 .... Ann Arbor
September 13-14 .. Grand Rapids

MOMI
August 11-15 .... Traverse City

Improving Productivity
September 11 .... Detroit
September 12 .... East Lansing
September 14-15 .. Mackinac

Advanced Coding
September 24 .... Marquette
September 25 .... Traverse City
September 26 .... Grand Rapids

Third Party Reimbursement
October 1 .... Detroit
October 2 .... Saginaw
October 3 .... East Lansing

Retirement Planning
October 16 .... Lansing

Stress Management
October 17 .... Grand Rapids

Medicare
October 22 .... Lansing
October 23 .... Detroit
October 24 .... Bay City

Getting the Most Out of Your PC
October 23 .... Detroit

Health Law Update - $^1/_2$ day
October 23 .... Detroit

AMA-MSMS Efficiency
November 4-8 .... To be determined

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Mowafak S. Asbahi, MD — GE/IM
18320 Farmington Rd.
Livonia 48152

Prameela D. Baddigam, MD — P
27514 Cordoba Dr. #4105
Farmington Hills 48334

Gary M. Balian, MD — P
854 N. Gate Rd.
Rochester 48306

Elissa P. Benedek, MD — P/CHP
P. O. Box 2060
Ann Arbor 48106

Ricardo D. Borrego, MD — AN/IM
18181 Oakwood Blvd. #208
Dearborn 48123

Ronald F. Budzik, MD — R
1517 W. Farnum
Royal Oak 48067

Robin D. Cook, MD — EM
2351 Plainfield, NE
Grand Rapids 49505

Maria A. Crumes, MD — R
15412 Rushmore
Taylor 48180

George F. Diehl, MD — FP
4150 S. River Rd. Suite D
St. Clair 48079

Neelam Dutt, MD — OBG
926 N. Michigan
P. O. Box 3216
Saginaw 48605

Carlos R. Estrada, DO — GS
P. O. Box 1773
East Lansing 48826

Jerry Ferrell, MD — FP
555 W. Wackerly #1600
Midland 48640

Jeffrey D. Forman, MD — R
16001 W. Nine Mile Rd.
Southfield 48037

Michael R. Gartner, MD — EM
1501 W. Chisholm
Alpena 49707

Laverne E. Gibson, MD — OBG
4707 St. Antoine
Detroit 48201

Jay M. Hartz, MD — P
444 Baldwin
Birmingham 48009

Catherine A. Henry, MD — IM
1338 Nicolet
Detroit 48207

Kathleen E. Jones, MD — FP
1639 Carla Drive
Essexville 48732

Raymond N. Jones, MD — GS
13400 W. Outer Dr.
Detroit 48239

Paul M. Kempen, MD — AN
3325 S. Adrian Hwy.
Adrian 49221

Muhammad A. Khan, MD — N
2277 Lovington St.
Troy 48083

Carol A. Krieg, MD — OPH
1015 S. Lincoln Rd.
Escanaba 49829

Jerome L. Kuhnlein, Jr., MD — IM/CD
3099 Wild Dunes Path
Stevensville 49127

Kathlene A. Kusiv, DO — OBG
926 N. Michigan
P. O. Box 3216
Saginaw 48605

Thomas A. Lalonde, MD — CD/IM
25990 E. Kelly Rd.
Roseville 48066

Gordon T. Lawless, MD — R
29965 Greening
Farmington Hills 48334

Todd E. Lininger, MD — AN
507 Linden
Birmingham 48009

Sudesh K. Mahajan, MD — IM/NEP
20861 Mack Ave.
Grosse Pte. Woods 48236

Robert I. Maxwell, MD — FP
4009 Orchard Dr.
Midland 48640

Mary G. McKinley, MD — DR
3725 Greenbrier Blvd. #187-B
Ann Arbor 48105

Seymour H. Mirkes, MD — R/NM
31262 Verona Dr.
Farmington Hills 48331

Elli F. Moller-Fabok, MD — IM
8899 Matthews Hwy.
Tecumseh 49286

Cheryl J. Mordis, MD — AN
1625 E. 13 Mile Rd. #205
Madison Heights 48071

Gerard M. Mosby, MD — PD
9000 E. Jefferson #1816
Detroit 48214

Lalitha Mutnal, MD — AN
206 S. Main Rd.
Three Rivers 49093

Sachin B. Nagarkar, MD — P
2110 Sixteenth St.
Bay City 48708

P. V.S. Nimmagadda, MD — IM/AN
4101-6 Green Isle Way
Saginaw 48603

Abdur Rasheed, MD — PD
1350 W. Bethune #605
Detroit 48202

Geoffrey M. Remes, MD — R
1008 Touraine Ave.
East Lansing 48823

Louis C. Remynse, III, MD — U
820 Lester Ave.
St. Joseph 49085

Richard K. Rosenstein, MD — OBG
2333 Biddle Ave.
Wyandotte 48192

Serge P. Schillio, MD — FP
1000 Houghton
Saginaw 48602

Jonna L. Schmidt, MD — IM/PD
791 Meadowbrook Dr.
Hudson 49247

Mala Sengupta, MD — PTH
6245 N. Inkster Rd.
Garden City 48135

Margaret Shusterman, DO — P
3835 Clyde Rd.
Holly 48442

Mark F. Silady, MD — IM
210 Lafayette, SE #302
Grand Rapids 49502

Blane L. Tacia, MD — GS
900 E. Michigan #103
Jackson 49201

DEATHS

Lawrence G. Bateman, MD
Flint

Lawrence G. Bateman, MD, a family physician, died October 23. He was 83. Doctor Bateman held a private practice in Flint from 1932 to 1986 and the last 37 of those years was assisted in his practice by his medical assistant Barbara Belanger. In 1972 he received an award from the Michigan State Medical Society for outstanding service. He was a life member of the American Medical Association, the Genesee County Medical Society, and MSMS.

Frank A. Cellar, MD
Royal Oak

Frank A. Cellar, MD, a psychiatrist, died October 10. He was 78. Doctor Cellar graduated from the University of Cincinnati and the University of Rochester. He worked at Harper Hospital, the Lafayette Clinic, and the Detroit Rehabilitation Institute. His private practice was in Huntington Woods. He served as a professor on staff at Wayne State University where he retired in 1982. Doctor Cellar was a member of the American Medical Association, the Michigan State Medical Society and a fellow in the American Psychiatric Association.

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Roger E. Fitzpatrick, MD
Bakersfield, California

Roger E. Fitzpatrick, MD, an anesthesiologist, died September 13. He was 51. Doctor Fitzpatrick received his pharmacy degree at Ferris State University and his medical degree from Wayne State University. He did an internship in Spokane, Washington from 1967 to 1971. His residency was served as an anesthesiologist at Balboa Hospital, San Diego, CA. He returned to St. Johns in 1974 where he held a private family practice. In 1977 he worked at Sparrow Hospital as an anesthesiologist until moving to Bakersfield, CA, in 1990 to take the position of Chief and Founder of the Anesthesiology Department at Kern Medical Center. Doctor Fitzpatrick was a member of the Michigan Medical Association, the American Medical Association, and MSMS.

Charles G. Jennings, MD
Grosse Pointe Woods

Charles G. Jennings, MD, a pediatrician, died October 4. He was 76. Doctor Jennings attended the University of Michigan and received his medical degree from Harvard Medical School. He served on staff at Children's Hospital, Detroit, for 16 years; St. John Hospital, Detroit; Bon Secours Hospital, Grosse Pointe and Jennings Hospital, Detroit. He served as a one time associate professor at Wayne State University School of Medicine. Doctor Jennings previously worked at his private practice on Detroit's east side for more than 20 years. He retired in 1982 from Children's Hospital where he had headed the hospital's physically and mentally handicapped division. Upon retirement he moved to Westchester, Ohio. Doctor Jennings was a member of the Wayne County Medical Society and the Michigan State Medical Society.

James W. Little, MD
Evanston, Illinois

James W. Little, MD, a radiologist, died October 14. He was 79. Doctor Little was a radiologist on staff at Mt. Carmel Mercy Hospital, Detroit, for 35 years retiring in 1985. Doctor Little lived in Bloomfield Hills before moving to Evanston in 1987. He was a member of the Michigan State Medical Society.

Joseph H. Naud, MD
Detroit

Joseph H. Naud, MD, a plastic surgeon, died September 3. He was 58. Doctor Naud received his bachelor of science degree from the University of Detroit and his medical degree from McGill University, Montreal. He studied plastic surgery at the University of Pittsburgh. In addition he was associated on staff with Detroit Receiving Hospital. He was a member of the American Medical Association, the Wayne County Medical Society, the Michigan Academy of Plastic Surgery, and MSMS.

Warren C. Pilling, MD
Grand Haven

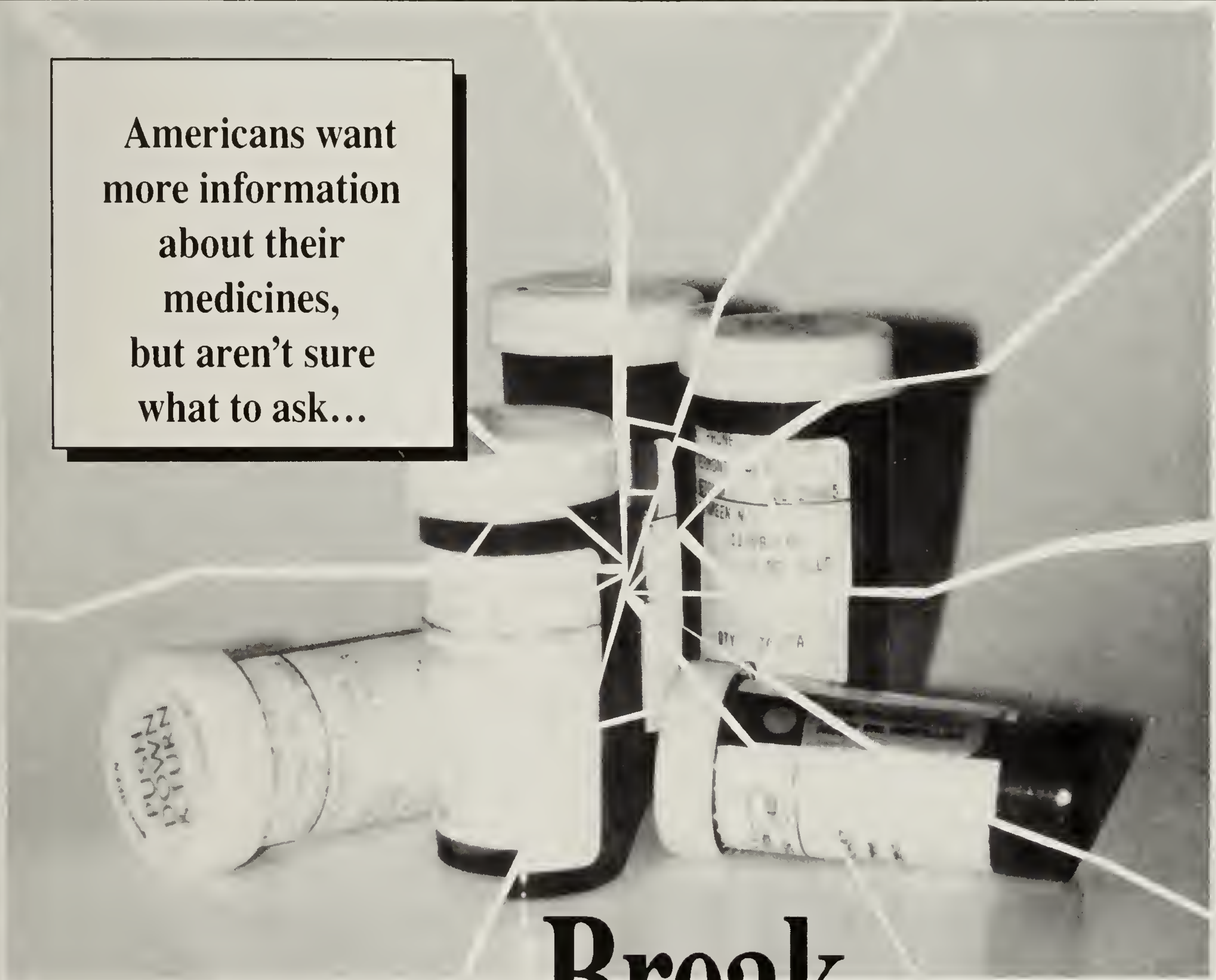
Warren C. Pilling, MD, an internist, died November 5. He was 65. He started his private practice in Grand Rapids in 1954. He was still practicing internal medicine in Grand Rapids after 36 years. Doctor Pilling was a founding partner of Grand Valley Nursing Center, now Grand Valley Health Center, and helped create the Internist's Lab. He was a member of MSMS.

Christopher J. Stringer, MD
East Lansing

Christopher J. Stringer, MD, a thoracic surgeon, died November 6. He was 85. Doctor Stringer received a bachelor of science and medical degrees from the University of Iowa, where he did his residency. He had practiced medicine in Lansing since 1938. Doctor Stringer served as the medical director of Ingham County Sanitarium, which became Ingham Medical Hospital. He retired in 1965. He was recipient of the Bruce Douglas Award for outstanding contributions in treatment of chest diseases. Doctor Stringer was a member of the Ingham County Medical Society and MSMS. In addition, he was a Fellow of the American College of Surgeons and the American College of Physicians.

John M. Trudeau, MD
Oak Park

John M. Trudeau, MD, a general practitioner, died October 4. He was 85. Doctor Trudeau was a graduate of Wayne State University School of Medicine. For 30 years he was on staff at Grace Hospital, Detroit. He also had several offices in Detroit where he practiced for 50 years. He was a member of the American Medical Association, the Wayne County Medical Society and MSMS.



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- ✓ WHAT FOODS, DRINKS, OTHER MEDICINES OR ACTIVITIES SHOULD BE AVOIDED WHILE TAKING THE MEDICINE;
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TALK ABOUT
PRESCRIPTIONS

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

January

8,15, A Case of Ulcerative Colitis. Location: 200 Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 4 hours Category I Credit.

22,29, Chronic Physical Disability. Location: 200 Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 4 hours Category I Credit.

February

1-2, Treatment Efficiency: New Drug, New Uses Seminar. Location: Sheraton Oaks Novi, Novi, Michigan. **Sponsor:** Michigan Psychiatric Society. **Contact:** Margaret Cole, Executive Secretary, (313) 647-7600. **Approved for:** 12 hours Category I Credit.

3-6, First Annual Mid-Winter Symposium. Location: Harbor Cove, Harbor Springs, Michigan. **Sponsor:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 7 hours Category I Credit.

3-8, 15th Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 22 hours Category I Credit.

5,12,19, Crohn's Disease: A New Understanding. Location: 200 Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, Bar-Levav Eduational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 6 hours Category I Credit.

11-15, Ninth International Postgraduate Course On Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. **Sponsors:** University of Michigan Medical School and Hannover Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 28 hours Category I Credit.

17-22, 16th Annual Seminar On Emergencies In Medicine. Location: Boyne Highlands Ski Lodge, Harbor Springs, Michigan. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

22-23, Endoscopic Sinus Surgery. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

22-24, 11th Annual Advances In The Management Of Infectious Diseases: Winter Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 13 hours Category I Credit.

March

3-6, A Symposium Featuring Fiberoptics - The Difficult Airway. Location: Red Lion's La Posada Resort, Scottsdale, Arizona. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-15, Emergencies In Medicine. Location: Yarrow A. Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

12,19, Vague But Persistent Heart Complaints. Location: 200 Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 6 hours Category I Credit.

26-4/2, Chronic Fatigue Syndrome: Fad or Fact? Contact: David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 4 hours Category I Credit.

15-16, Recent Trends In Electrophysiologic Assessment Intraoperative Applications. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

19-23, Family Practice - 1991: Fifteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 35 hours Category I Credit.

21-24, 11th Annual Advances in The Management of Infectious Diseases: Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201,

Continued on page 45

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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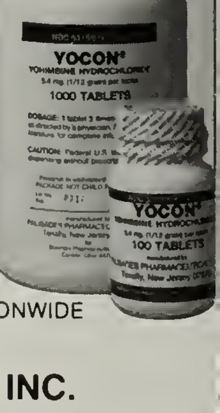

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CATEGORY I COURSES

Continued from page 42

(313) 763-1400. **Approved for:** 12 hours Category I Credit.

22, A Study In Hope: The Treatment and Management Of Alzheimer's Disease. Location: Fetzer Development Center, Western Michigan University, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies, Alzheimer's Disease and Related Disorders, Chapter of SW Michigan, and Kalamazoo Neurology. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 6.5 hours Category I Credit.

23-24, Regional Anesthesia: Anatomy & Techniques. Location: Wayne State University School of Medicine, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 12 hours Category I Credit.

April

4-5, Challenges and Changes: Obstetrics and Gynecology In The 1990's. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University Of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-12, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 21 hours Category I Credit.

26-27, Evaluation and Management of Valvular Insufficiency. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Angela Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 764-2288. **Approved for:** 15 hours Category I Credit.

29-5/5, Advances In Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 33.5 hours Category I Credit.

May

3-5, The Treatment of Anxiety: A Psychotherapeutic Approach. Location: Hyatt Regency Suites, Chicago, Ill. **Sponsor:** Bar-Levav Association. **Contact:** James McCarthy, 200 Fisher Buyilding, Detroit, MI 48202, (313) 872-1300. **Approved for:** 20 hours Category I Credit.

16-17, The Restenosis Summit III. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763- 1400. **Approved for:** 16 hours Category I Credit.

17-18, 63rd Annual Ophthalmology Spring Postgraduate Conference: Lasers In Ophthalmology. Applications and New Developments. Location: University of Michigan. W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical SChool, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 13 hours Category I Credit.

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MEETINGS

MSMS Meetings

January

16, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

March

7, MSMS Young Physicians Section, Annual Meeting, Kellogg Center, East Lansing, MI. Contact: Debbie Zannoth, Chief, Membership Department (517) 337-1351.

13-14, MSMS Maternal and Perinatal Annual Conference, Ritz Carlton, Dearborn, MI. Contact: Sherry Fent, Chief, Physician Education (517) 337-1351.

16, MSMS Hospital Medical Staff Section 7th Annual Assembly. Contact: F.B. "Tom" Plasman, Manager, Physician/Hospital Relations, (517) 337-1351.

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

23, MSMS International Medical Graduates Annual Meeting, Ritz Carlton, Dearborn, MI. Contact: Judy Marr, Manager, Communications (517) 337-1351.

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

AMA Meetings

February

13-15, National Communications Conference, Miami Beach, FL. Contact: American Medical Association, 515 North State St., Chicago, IL 60610.

15-17, National Leadership Conference, Fontainebleau Hilton, Phoenix, AZ. Contact: Stephanie Jaworskyj, Meeting Management (312) 464-5341.

Michigan Specialty Society Meetings

January

25-27, Continuous Medical Advancement Midwinter Seminar, Harper Woods, MI. Contact: (313) 527-7172.

February

16, Film presentation: "Crimes and Misdemeanors", Farmington, MI. Contact: Colleen Jaeger (313) 559-5855.

28, "The Ego Resistances", Southfield, MI. Contact: Colleen Jaeger (313) 559-5855.

Continued on next page

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MEETINGS

Continued from previous page

April

21-23, Uniting to Support Infants and Families in Crisis, University of Michigan Campus, Ann Arbor, MI. Contact: Kathleen Baltman (313) 577-5244.

National Specialty Society Meetings

January

17-19, American Academy of Pain Medicine, Annual Refresher Course and Scientific Meeting, Miami, FL. Contact: Cathy Crabbe (708) 966-9510.

18-20, Midwest Forum on Allergy, Dearborn, MI. Contact: Vi Heins (517) 336-7570.

February

18-20, Society of Thoracic Surgeons, San Francisco, CA. Contact: (312) 664-6610.

24-28, American Institute of Ultrasound in Medicine, Atlanta, GA. Contact: (301) 656-6117.

March

1-3, Neurology in Clinical Practice, Telemark Resort, Cable, WI. Contact: (507) 284-2509 or Toll Free (800) 323-2688.

1-6, American Academy of Allergy & Immunology, San Francisco, CA. Contact: (414) 272-6071.

3-7, American College of Cardiology, Atlanta, GA. Contact: (301) 897-5400.

7-12, American Academy of Orthopaedic Surgeons, Anaheim, CA. Contact: (708) 823-7186.

16-21, American Academy of Pediatrics - Spring Session, San Diego, CA. Contact: (708) 228-5005.

23-26, American Society on Aging, New Orleans, LA. Contact: (415) 543-2617.

April

11-13, American Society of Abdominal Surgeons, Tampa, FL. Contact: (301) 483-5471.

11-14, American College of Physicians, New Orleans, LA. Contact: (215) 351-2400.

21-23, National Council on Patient Information and Education, Washington, DC. Contact: (202) 347-6711.

21-25, American Association of Neurological Surgeons, New Orleans, LA. Contact: (708) 692-9500.

21-26, American Association of Immunologists, Atlanta, GA. Contact: (301) 530-7178.

21-27, American Academy of Neurology, Boston, MA. Contact: (612) 623-8115.

28-5/2, American Urological Association, Las Vegas, NV. Contact: (301) 727-1100.

29-5/3, American Pediatric Society, New

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MEETINGS

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May

3-6, Association of American Physicians, Seattle, WA. Contact: (609) 848-1000.

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gatroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-6/1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

Other Meetings

January

21-22, Making Sense Out of Medicare in 1991, San Diego, CA. Contact: (301) 961-8708 or Toll Free (800) 999-0463.

February

28-3/1, Children's Defense Fund Annual National Conference, Washington, DC. Contact: Donna M. Jablonski (202) 628-8787.

March

1-3, Mayo Foundation, Neurology in Clinical Practice, Cable, WI. Contact: (507) 284-2509 or Toll Free (800) 323-2688.

10-15, 12th Annual Mammoth Mountain Emergency Medicine Ski Conference, Mammoth Lakes, CA. Contact: (714) 650-4156.

14-16, Brain Chemistry and Behavior: Advances in PET and SPECT Imaging, Baltimore, MD. Contact: Patty Campbell (301) 955-3839 or Julia W. Buchanan (301) 955-8582.

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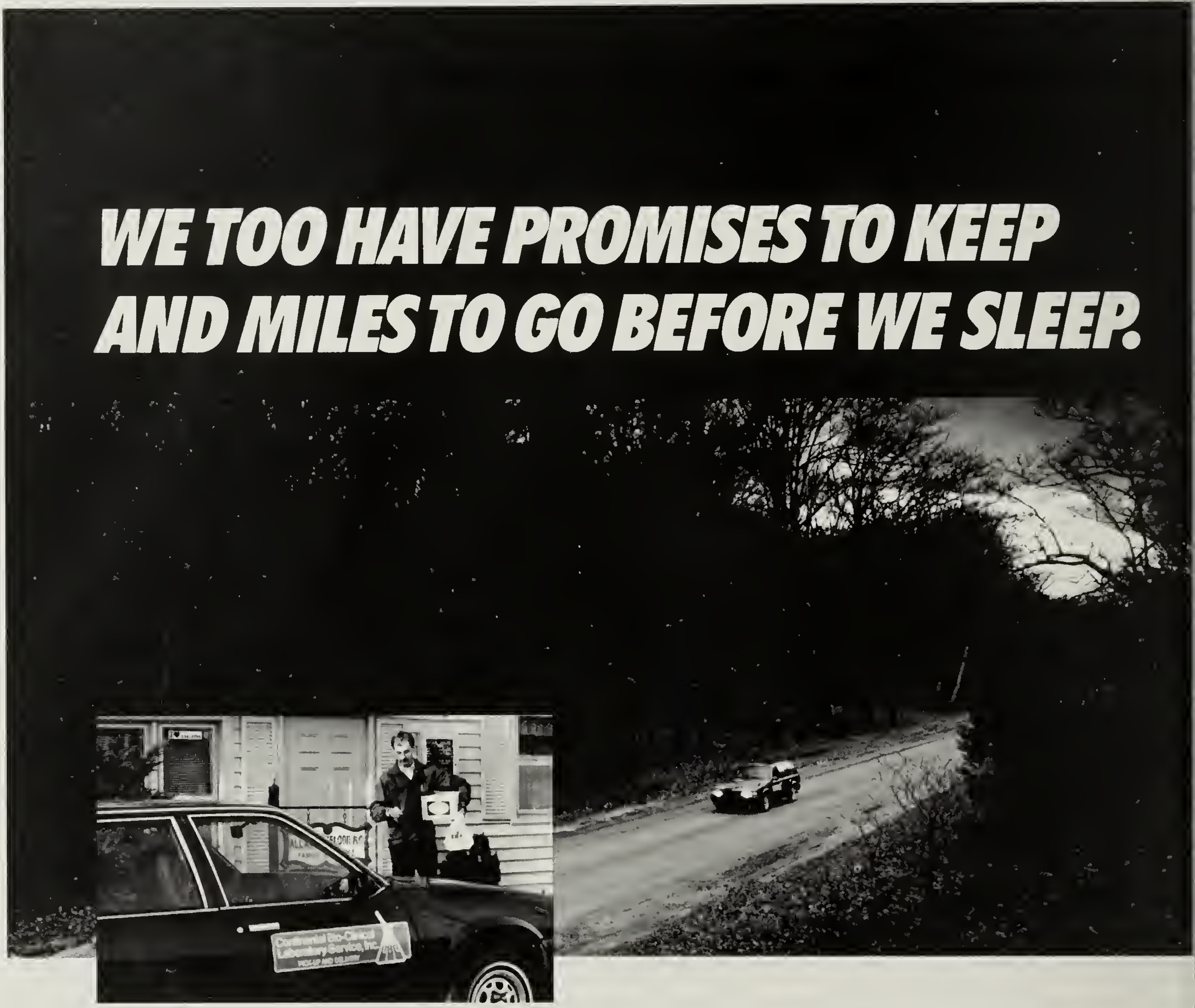
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Medical Billing Service	2
Medical Search Group	51
Metric Medical Labs	48
MPMLC	IFC, 36
Palisades Pharmaceutical	44
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Continued from page 56

arbitrators have not been uniformly established, a growing body of practitioners now serve as full-time third party neutral dispute resolvers. They usually take mediation courses of some 40 hours in length, and they must have the personality and temperament to remain neutral during tense negotiations.

Incidentially, retired physicians could become mediators. They would be ideal for mediating fee disputes or disputes between doctors and hospitals. This latter could be important, in view of a recent counterproposal from the trial lawyers that hospitals be the sole defendent in all hospital-associated suits. Physicians might like protection from these suits, but it is easy to see how it could set hospitals and physicians against each other, creating plenty of disputes to resolve.

Texas has legislation which facilitates the use of alternative dispute resolution (ADR) systems for all disputes. The law defines mediation, arbitration, settlement conferences, and mini trials, specifying the qualifications of mediators and arbitrators. Parties to a dispute can choose their format, with no obligation to mediate before arbitration. Most choose mediation. In the past two years, both Texas and Florida have started using mediation in professional liability suits, and judges often order the parties to mediate before accepting a case in court. We could do worse than this. It is not mandatory mediation or arbitration, but it comes without onerous tradeoffs.

Federal and state case law protect the confidentiality of mediation settlements, to encourage alternatives to trial by jury. The new National Practitioner Data Bank reporting requirements fly in the face of these incentives. We may find support if we seek an exception to reporting requirements which push us to go to trial instead of settling. This exception would be important if mediation or arbitration became mandatory.

Since many Michigan physicians are confused about mediation and arbitration, we should begin referring to ADR, e.g. alternative forms of dispute resolution. ADR usually means some combination of settlement conference, mediation or arbitration. This term allows us to properly define our subject and straighten out the confusion. The bottom line is that we better know what it is we want to change to, if our goal is to change the present system. ■

Doctor Adelman is MSMS president.

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PRESIDENT'S PAGE

Alternative forms of dispute resolution — We must be clear on what we want

By Susan H. Adelman, MD

Today in Michigan, after thousands of hours of effort spent trying to solve it, our professional liability problem is still with us, as big as life. Though 80 percent of the cases settle out of court, and though 80 percent of the court cases go on to a no cause, jury awards are rising, some making headlines, and our premiums remain unacceptably high. We all agree that the system must be changed. The problem is: To what?

MSMS has worked for months with Governor Blanchard's special factfinder, Robbin Fleming, PhD, in search of a recommendation which physicians, hospitals, insurers, and lawyers could all support. Professor Fleming has proposed a mandatory settlement conference, followed by mandatory nonbinding arbitration, an expedited system for handling small claims, and a three-tiered cap on awards. However, the Bar insists that, in return for a cap, the medical profession agree to mandatory proof of financial responsibility. This means mandatory professional liability insurance, enforced in the final recommendations by insistence that hospitals only have access to the streamlined systems if all of their physicians are insured. Other tradeoffs included periodic physician retesting and relicensure and improved risk reduction. The final report greatly expands the risk reduction proposals, and places the process under state direction and supervision, linked to licensure and hospital privileges.

Now we have a new governor and an opportunity to start afresh. What if we were to provide him with recommendations developed by physicians, hospitals and insurers together, without the lawyers? We are the parties who can best agree. We might propose a menu approach, spelling out criteria for mediation, arbitration, or a worker's compensation style administrative board. Above all, for any proposal to work, the insurers need to give us meaningful premium reductions. What if physicians who agree to mandatory mediation would receive a substantial discount off premiums? Would this help? Certainly we would be better off working these ideas out among ourselves than asking the legislature to design a system for us.

Mediation and arbitration

Let us now look at mediation and arbitration, subjects on which most of us need more education. We already have the option of arbitration, and we have something called pre-trial mediation. With arbitration optional in Michigan, doctors prefer to take "good" cases to court and "bad" cases to arbitration. Thus, arbitration awards have been higher than jury awards.

Michigan's "pretrial mediation panels" do not mediate at all. The parties argue their case before a panel which usually consists of lawyers, and perhaps one or two physicians. This panel decides the case, then it advises the court of its decision. Most of these panels just pick an award which they think will prevent the case from cluttering the court docket. Though misnamed, this has given mediation a bad name. It actually is nonbinding arbitration, or advisory arbitration.

Mediation is defined as "The intervention of a third party neutral who, intervening with the permission of the parties, assists them in finding a mutally acceptable, non-coercive and conscionable exit from their conflict that is definite, specific and performable." These settlements (not awards) are nondiscoverable and strictly confidential. Mediators cannot serve as witnesses at a subsequent trial. The parties in a mediation are not compelled to settle, but in 80 percent of the cases, they do. Mediation does not automatically bind the parties to a form of payment, and it is not biased toward the plaintiff, although if a defendent physician has absolutely no intention of ever paying a dime, the prognosis is poor for mediation. Mediated agreements may have special features, such as an apology in lieu of payment, a waiver of charges for certain services, or a financial settlement accompanied by an agreement in writing that there was no negligence.

There is a nationwide professional organization for mediators and arbitrators, the Society for Professionals in Dispute Resolution. The immediate past president is Edward Hartfield, whose office is in Southfield. He and his colleagues emphasize that mediation is more effective than arbitration in resolving medical professional liability disputes, because the parties have relatively little to lose.

Since mediation does not require the evidence, exhibits, witnesses, and testimony that are involved in arbitration and litigation, it can be quickly arranged, is confidential, and is relatively inexpensive. In a well-designed dispute resolution system, involvement of a mediator in the 80 percent of professional liability disputes which now settle could allow these settlements to proceed to a more satisfactory, expeditious result.

The reason for this lies in the value of the mediator. Frequently, parties involved in a dispute are reluctant to explore settlement options until they have a secure feeling that settlement is possible. By working back and forth between the parties, the mediator can explore settlement possibilities in confidence without jeopardizing the positions of either side. This maximizes the probability of the process being quick, quiet, fair, and impartial. While none of this but the part about quick payment may excite lawyers, it should appeal to plaintiffs and defendents. Plaintiff's lawyers might also respond if reminded that if they refuse mediation and then lose in court, they could be sued for legal malpractice.

While clearly defined licensure and certification requirements for mediators and

Continued on page 55

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MICHIGAN MEDICINE

14 COVER STORY

Availability, peer pressure and role models at home of older relatives and neighbors who may drink or use drugs make it more and more difficult for children at even early ages to avoid exposure to drug abuse. To help educate kids about the legal and medical ramifications associated with drug abuse, teams of Michigan physicians, lawyers and law enforcement officials recently visited 156 Detroit elementary schools to talk with students. "It was quite shocking when I asked the students how many knew people who had been jailed or died from substance abuse or how many knew what a crack baby was like," said MSMS President Susan H. Adelman, MD. MSMS played a key role in forming these teams of professionals. How this effort came about and what plans MSMS has for future visits is the subject of this month's cover story. Also included are photo highlights of the visits made to Detroit area schools last October and November.

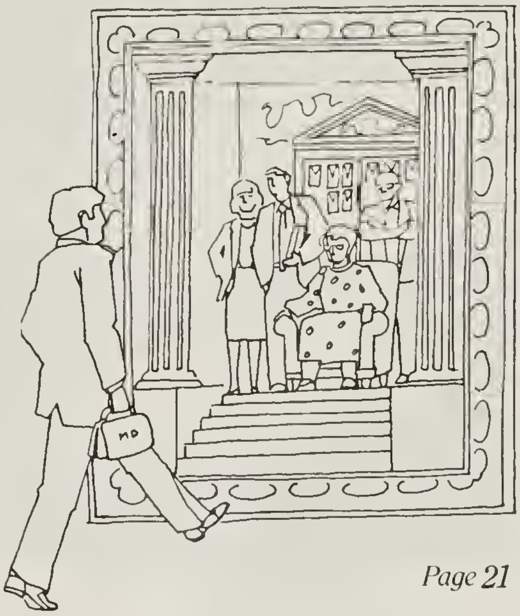
Page 14

FEATURES

21 PHYSICIANS, GUARDIANSHIPS AND THE COURTS

Courts are receiving increasing numbers of guardianship petitions for older persons. And when older persons find themselves the subject of a guardianship petition, there usually is, or should be, a physician in the picture somewhere. What the physician should be able to expect from the courts in such cases and visa versa is the subject of this article.

– BY JOHN N KIRKENDALL



Page 21

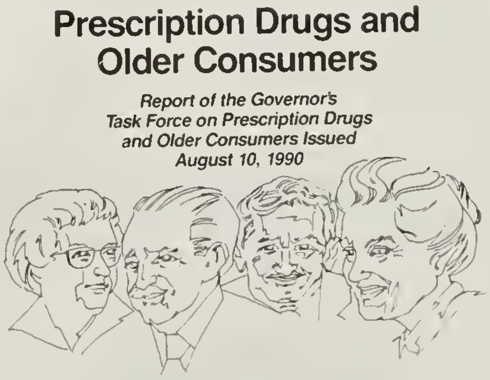
25 PRACTICE MANAGEMENT

Practical suggestions for unsnarling your appointment schedule.

– BY GEORGE S. CONOMIKES

27 PRESCRIPTION DRUGS AND OLDER CONSUMERS

Highlights of the Governor's 1990 report of the Task Force on Prescription Drugs and Older Consumers. Also included is a complete list of recommendations for physicians.



Prescription Drugs and Older Consumers

Report of the Governor's Task Force on Prescription Drugs and Older Consumers Issued August 10, 1990

Page 27

DEPARTMENTS

7 Letters
9 Newsfronts
10 Physicians in the News
34 New Members
37 Deaths
38 Meetings
41 Category I Courses
45 Classifieds
47 Advertising Index
48 President's Page
"Obtaining medical information – State legislation is needed"
BY SUSAN H. ADELMAN, MD

In next month's issue of *Michigan Medicine*:
Medical reimbursement trends.
Cover illustration by: *Robert L. Brent.*

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Letters from Our Readers

All children deserve to have their basic needs met

Freedom of Religion is one of our country's greatest rights. While the Constitution guarantees the right of an individual to believe whatever he or she wishes, it does not allow one to use those beliefs to bring harm to others. Parents who deny needed medical care to their children because the parents believe that prayer, or some other religious practice, is more efficacious are harming their children.

Parents have many prerogatives in the rearing of their children. However, in exchange for the opportunity to raise their children as they desire, the parents also have certain obligations to these children; to feed them, to clothe them, to see that they are educated, to keep them free from harm, and to provide for their medical care.

All children deserve to have their basic needs met, regardless of the attitudes or beliefs of their parents. That is an obligation our society has determined to be one of the hallmarks of a just and caring people. The vast majority of parents provide these basic needs for their children, and in the occasional situation when this does not happen, our judicial system intervenes on behalf of the child.

Because of legislation passed over 15 years ago, Michigan, along with some other states, has one exception to the ability to assure our children that their basic needs will be met. In the regulations pertaining to child abuse and neglect, Section 14 reads: "A parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone, shall not be considered a negligent parent or guardian." That section, and others like it in other states, has led to the death of children across the country from diabetes, meningitis, bowel obstruction, and other illnesses that are fatal if not given prompt medical attention. On April 17, 1990, the *US Supreme Court*, in a ruling on a case from Oregon, stated: "We have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law." That statement, combined with previous decisions that freedom of religious belief does not allow one to harm others, makes it clear that our state legislature should repeal Section 14 if we are to provide the basic needs of childhood to all children in Michigan.

In a number of cases from Massachusetts to California, criminal charges of manslaughter have been affirmed against parents who allowed their children to die while pursuing religious healing in lieu of medical care. Certainly, these parents bear the responsibility for their decisions. Freedom of religion also implies that parents, as adults, have the freedom to modify their views if they believe they may bring harm to others, such as their children. These are the kinds of choices we all must make in the adult world. How one should respond to the adult who chooses to adhere to beliefs that may bring harm is a difficult question. Whether the onus for these kinds of decisions should be extended to those who promulgate, reinforce, or attempt to coerce such decisions is an even more difficult question, because these individuals may, too, be acting on behalf of their own strongly held views. How far the culpability for decisions that bring harm to children should be extended is a matter which deserves careful consideration.

This year the Board of Trustees of the American Medical Association in Resolution H (A-90) stated under the heading of Legal Issues: "The constitutional guarantee of freedom of religion is a cherished right, but the Board has recognized that its preservation is not limitless and does not sanction harm to others. Laws may not interfere with mere religious beliefs and opinions, but they may interfere with practices. *Reynolds vs. United States*, 48 US 145 (1989)." And later: "The AMA also recognized the need of the public to be aware of the basis upon which all practitioners, including religious healing practitioners, make their claims, and all such practitioners should be held accountable for asserting misleading, false or deceptive claims with respect to their practices."

The purpose of generating these remarks is to inform those that are interested in these issues that there will be introduced into the legislature in 1991, several bills that are designed to protect the interests of children and assure for all of our children equal protection under the law and equal access to their basic needs, including medical care when they are seriously ill. This is the least we can do for this most vulnerable segment of our society. Letters to your legislators supporting these efforts will be an excellent way to wish all children a healthy and loving New Year.

William B. Weil, Jr., MD
Professor, Pediatrics and
Human Development
Michigan State University

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MEDICAL NEWSFRONTS

INDEX

WSU receives grant to study head injury 9
State infant mortality rate rose in 1989, MDPH reports 9
U-M launches lung transplantation program 10
Students can apply for research awards 11
$150,000 awarded for research on senior citizen health care 11
Pilot project makes impact on physician reporting 11
New technology allows doctors to "see" inside heart's blood vessels 12

WSU receives grant to study head injury

The Department of Pharmacology at Wayne State University School of Medicine has received a $35,000 post-doctoral grant from the Von Bulow Coma and Head Trauma Research Foundation for research into possible acute treatments for closed head injuries, particularly those caused by automobile accidents and which involve alcohol.

Marilyn Morehead, PhD, research associate, under the supervision of Harold Goldman, PhD, professor, is studying the effect of alcohol intoxication at the time of injury, as well as treatment to prevent the secondary injury in the form of swelling of the brain. In an attempt to prevent secondary head injury, Doctor Morehead is employing approaches which simulate the body's own reparative mechanisms.

The grant began November 1, 1990, and will continue for one year. Awards are made to US academic medical centers for physicians/scientists supervising junior researchers who demonstrate academic promise in this subspecialty. Only five grants of this kind are made annually.

State's infant mortality rate rose in 1989, MDPH reports

Michigan's infant mortality rate for 1989 rose to 11.1 compared to the 1988 rate of 11.0, according to a recent report released by the Michigan Department of Public Health.

There were 1,645 infant deaths in 1989, 103 more than in 1988. The rate for white infants decreased from 8.6 in 1988 to 8.3 in 1989, while the rate for black infants remained the same at 21.9. The decrease in the white infant mortality rate, coupled with no change in the black infant mortality rate, has once again widened the gap between white and black infant mortality. The infant mortality rate is based on the number of babies who die in their first year of life per 1,000 live births.

In 1989, births in the state increased by 8,529 to a total of 148,164 from 139,635 in 1988. Michigan's 6.1 percent increase in births is the largest gain in the number of live births since 1956 and the largest percent increase since 1951. Nationally, the provisional number of births increased 2.9 percent in 1989. There was a 2.5 percent increase in the state's number of white infants born in 1989, with 113,724 born in 1989 compared to 11,982 in 1988. There was an 18 percent increase in the state's number of black infants born in 1989, with 30,730 born in 1989 compared to 26,034 born in 1988.

In Detroit, the infant mortality rate increased from 20.9 to 21.3. The black infant death rate in Detroit increased from 23.0 in 1988 to 23.8 in 1989. The white infant death rate in Detroit decreased from 13.6 to 10.9 during the same period.

Births in Detroit increased at a higher rate than the state as a whole. In 1989, there were 22,721 births compared to 19,729 in 1988. This is an increase of 15.1 percent and is five times the percent of national increase.

Statewide, there were about the same number of infant deaths that occurred in the first four weeks of life in 1989 and 1988, 1,070 versus 1,068; however, there were 101 more infants that lived four or more weeks but died before their first birthday.

The number of low weight births increased from 10,237 in 1988 to 11,323 in 1989, bringing the state's percentage of low birth weight babies up from 7.3 percent to 7.6 percent. The number of very low birth weight infants increased from 2,018 in 1988 to 2,256 in 1989. This is an increase of 11.8 percent over 1988. About 40 percent of very low birth weight infants die before their first birthday.

The percentage of women receiving adequate prenatal care has declined from 72.3 percent in 1988 to 70.8 percent in 1989 and the percentage of women receiving inadequate prenatal care has increased from 6.2 percent in 1988 to 7.3 percent in 1989.

Michigan began several new programs designed to help women get into early prenatal care in the mid-eighties. As a result, infant mortality began to go down and the number of women entering prenatal care in their first trimester improved. However, the state began to experience a shortage of doctors willing to practice obstetrics due to concerns about malpractice and high insurance premiums. In addition, a ban on paying Medicaid abortions was enacted in December 1988 and drug usage during pregnancy increased during these years in Michigan, as well as across the country. All of these new factors intervened and the state's progress in reducing infant mortality came to a halt.

The dramatic increase in the state's births, the continuing rise in low birth weight infants, and the growing number of infants who survive the first month of life but die before their first birthday also are reducing the impact of efforts directed at the reduction of infant mortality.

New initiatives begun in 1990 include "Baby Your Baby," a major statewide public information campaign supported by Blue Cross Blue Shield, the March of Dimes, the Michigan Association of Broadcasters, and the Michigan Cable Television Association, as well as numerous other organizations. The campaign was launched last May to inform pregnant women about the importance of early and continuous prenatal care and how and where to get it. The campaign also provides education on the effects of unhealthy behavior, such as smoking and drinking, on infant health. Calls to the state's prenatal care hotline increased by 400 percent

Continued on page 10

Continued from previous page

since the campaign began in May, 1990.

A new law called the Michigan Essential Health Provider Act was passed by the legislature this past spring. It provides subsidies in the form of loan forgiveness to encourage physicians to locate in undeserved areas.

Michigan has also established four new centers which provide prenatal care and substance abuse treatment to pregnant women, increasing treatment slots from 100 to 550. It is estimated that up to 15,000 Michigan infants may be drug-exposed each year. The most frequent effects of drug exposure on infants are low birth weight and prematurity. Although the long-term effects of prenatal drug exposure are unknown, the costs of providing services to seriously affected children can cost as much as $750,000 per child to age 18, according to a federal General Accounting Office report, "Drug Exposed Infants."

When programs to improve access to prenatal care and to prevent drug use during pregnancy are fully implemented, the results are dramatic. According to this same federal report, the incidence of low birth weight among infants born to drug-abusing mothers dropped from 50 percent to 18 percent when they participated in a drug treatment program set up for pregnant women.

State public health officials believe the new initiatives begun in 1990 will begin to have a beneficial effect over the next few years, but question whether the dramatic increase in births which is expected to continue during 1990 will stretch to the breaking point already over-burdened public programs designed to provide health care to high risk women and their infants. In 1987, a statewide task force released a report calling for a five-year infant mortality reduction plan. In light of the new factors that have occurred since 1986, the department believes a reassessment of the problem is warranted.

For more information, call (517) 335-8024.

U-M launches lung transplantation program

Three Michigan residents suffering from severe lung disease are breathing easier after undergoing the state's first lung transplants at the University of Michigan Medical Center.

The three patients, all of whom received a single donor lung within a six-week period, showed dramatic improvements after surgery, according to surgeons who performed the procedures.

The lung transplantation program is the newest in a range of services provided by Michigan Transplant, the U-M center for organ transplantation. Established in 1984, Michigan Transplant offers comprehensive clinical, educational and research programs transplant for all major organs — kidney, liver, bone marrow, cornea, pancreas, heart and lung. Double-organ procedures such as heart/lung and kidney/liver transplants also are performed.

A team of six surgeons and anesthesiologists, technicians, nurses, physician assistants and perfusionists retrieved and transplanted the donor lungs. The patients, who were struggling to breathe and severely limited in activity before transplant, showed remarkable improvement shortly after their three- to five-hour surgeries.

"Their recovery stunned everybody. They went from being blue and sitting in a wheelchair gasping for breath to sitting up and talking to you the next day. To watch someone suffocate and gasp for air is the most awful thing you can see. To see them afterward was really dramatic," said Michael Deeb, MD,

Continued on page 11

Physicians in the News

Howard Feit, MD, senior staff neurologist, Henry Ford Hospital, is recipient of the Joseph L. Ponka Caring Physician Award. The award, named after Joseph L. Ponka, general surgeon and medical director, Henry Ford Medical Center, was presented to Doctor Feit for "going beyond the call of duty and exemplifying the qualities of a caring physician." The award was established by a group of physicians at the West Bloomfield Center in honor of **Joseph L. Ponka, MD,** for the caring qualities that he portrays every day of his life. The award will be given annually to a physician who meets the high personal standards of patient care.

Randall Johnson, MD, director of the Marquette County Health Department, is recipient of the J. Howard Beard Award. The award, which the County received from Health Officials for its "Innovations in Food Service Sanitation" program, was presented at the association's 1990 annual conference. The award recognizes outstanding significant and exemplary activities of local health departments. The food service sanitation program targeted automating inspection and activity reports and implementing a use-based food service license fee system.

Michigan Society of Pathologists has a new slate of officers. They are: **Cathy O. Blight, MD,** president; **Mark D. Kolins, MD,** president-elect; **Thomas McCormick, MD,** secretary/treasurer; and **Arnold R. Dood, MD, John Schaldenbrand, MD, and Aaron Lupovitch, MD,** trustees.

David Rovner, MD, professor of medicine and chief of the Division of Endocrinology and Metabolism, Michigan State University, is the newly-elected president of the Michigan Affiliate of the American Diabetes Association. Doctor Rovner will serve as the ADA-Michigan Affiliate president for a one-year term.

Manuel Dujovny, MD, Department of Neurosurgery, Henry Ford Hospital, is editor-in-chief of the journal *Neurological Research.* Published quarterly, the international journal reports both basic and clinical research in the fields of neurosurgery and neurosciences.

David B. Cotton, MD, is the newly-appointed chairman of the Department of Obstetrics and Gynecology, Wayne State University, and chief of obstetrics and gynecology, Hutzel Hospital in The Detroit Medical Center. Doctor Cotton was formerly professor of obstetrics and gynecology at Baylor College of Medicine, Houston, where he was director of the Maternal-Fetal Medicine Division at St. Luke's Episcopal Hospital.

Alan N. Dengiz, MD, director of Geriatric Medicine, Catherine McAuley Health System, Ann Arbor, has been named Geriatrician of the Year by the Michigan Affiliate of the American Geriatrics Society. At the same time, he has been nominated for the 1991 AGS/Marion Merrell Dow Geriatrics Clinician of the Year Award.

Continued from previous page

director of the Medical Center's Cardiac Transplantation-Artificial Heart program, who led the transplant team.

Currently, about a dozen patients are on a waiting list at the U-M to receive a lung transplant. The procedure is limited by the scarcity of healthy donor organs. About 30 percent of patients on the list may die before an organ becomes available, Deeb said.

According to the United Network for Organ Sharing, more than 130 patients nationwide have received lung transplants since 1987.

The U-M Medical Center performed the first kidney, liver, heart, lung, heart-lung and artificial heart transplant in Michigan. Since 1968, 163 heart transplants and one heart-lung transplant have been performed at the U-M. Two patients with failing hearts have been placed on an artificial heart that supported life functions until a donor heart could be obtained. Other types of mechanical heart support used at the U-M are ventricular assist devices, the Hemopump, and extracorporeal membrane oxygenation (ECMO).

The U-M lung transplant program involved intensive training for all members of the transplant team. Experience gained through practicing the procedure on dogs contributed to the success of the transplants.

Students can apply for research awards

Students enrolled in medical or doctoral programs at Michigan universities who are interested in health or medical research are invited to apply for the 8th Annual Student Awards Program sponsored by the Michigan Health Care Education and Research Foundation (MHCERF), the research and philanthropic affiliate of Blue Cross and Blue Shield of Michigan.

The program provides grants of up to $3,000 for research aimed at improving health and medical care in Michigan. Monies are awarded for research studies, pilot projects, interventions and demonstrations, feasibility studies, proposal development and critical literature reviews.

Projects must involve quality of care, cost containment, or a combination of both; target a major public health or medical issue and focus geographically on Michigan. Applicants must be enrolled in MD, DO, or doctoral programs.

Applications are available from the Student Awards Program, MHCERF, 600 Lafayette East, Mail Code B243, Detroit, Michigan, 48226. Deadline for applications is April 30, 1991.

For further information, contact MHCERF at (313) 225-8706.

$150,000 awarded for research on senior citizen health care

Research to improve health care delivery to senior citizens in Michigan is the focus of three grants totaling more than $150,000 awarded by the Michigan Health Care Education and Research Foundation (MHCERF), the research and philanthropic affiliate of Blue Cross and Blue Shield of Michigan.

A $56,310 grant to estimate the demand for long-term care facilities in Michigan and the cost and policy implications that may arise from that demand goes to Jersey Liang, PhD, a researcher at the University of Michigan.

When completed, the forecast will be the most comprehensive in Michigan.

A joint grant of $55,206 goes to Neal W. Persky, MD, of the U-M Institute of Gerontology, and Robert C. Burack, MD, of the Department of Internal Medicine, Wayne State University, to complete their three-year study of mammography screening for the early detection of breast cancer among a test group of elderly women at the U-M Medical Center.

Researchers hope to determine why some elderly women did not follow through on screening and what role doctors played in their decision. Doctors Persky and Burack also will evaluate ways that doctors can intervene to encourage more women to take the exam.

A $50,000 grant to develop an educational program to help physicians deliver lower cost medical care to the elderly without compromising quality of care goes to John E. Billi, MD, of the Department of Internal Medicine at U-M Medical School.

Doctor Billi will develop an inexpensive, continuous educational program for physicians, medical students and medical support staff who deliver geriatric medical care.

The program will be used for one year by a group of physicians at the U-M Hospital who will receive monthly orientations on common geriatric procedures and cost saving strategies.

The three awards are part of MHCERF's on-going grant programs which provide support to researchers interested in developing projects that focus on improving the quality, while containing the costs, of health care in Michigan.

For further information on grant programs, call MHCERF at (313) 225-8706.

Pilot project makes impact on physician reporting

In April, 1988, the Michigan Department of Public Health, in cooperation with Michigan State University, joined a network of 10 states selected to participate in a program with the Centers for Disease Control (CDC). The program is called SENSOR (Sentinal Event Notification System for Occupational Risks).

The goal of this program is to improve occupational disease surveillance. All physicians in Michigan have been required since 1978 to report *known* or *suspected* cases of occupational disease to the Michigan Department of Public Health (MDPH) under Part 56 of P.A. 368 of 1978. The SENSOR Program is a special initiative to encourage physicians to report two occupational diseases: silicosis and occupational asthma.

In the spring of 1988 approximately 3,000 Michigan physicians received a special mailing from the Michigan Department of Public Health. Since that time, physician reporting of all occupational disease (including the targeted conditions listed above) has jumped from 100 reports a year to over 5,000 reports in the first eight months of 1990. To date, Project SENSOR has received 195 reports of suspected occupational asthma and 364 reports of silicosis.

Incentives for reporting include:

- availability of an expert in occupational disease for telephone consultation
- free literature search
- free interpretation of x-rays for pneumoconiosis
- information and reports on the patient's exposures
- referral of symptomatic co-workers to the reporting physician.

After a report is received, a SENSOR staff person first contacts the physician. If there is no contraindication the patient or a next-of-kin is interviewed to obtain a work and medical history. Doctor Kenneth Rosenman, a certified "B-Reader" and Primary SENSOR Investigator at Michigan State University, evaluates the worker's roentgenogram for pneumoconioses (in silicosis case reports), and reviews medical records. This information is then used to assist the Michigan Department of Public Health Industrial Hygienist during the subsequent worksite investigation. Sensor staff

Continued on page 12

Continued from page 11

accompany the health department during investigations and when appropriate, administer questionnaires to coworkers and /or review workers' X-rays.

Participating physician response has been strong in Michigan. There were 77 Project-Sensor initiated worksite investigations in the first 24 months of the project; 53 for occupational asthma and 26 for silicosis. Two worksites were investigated based on both occupational asthma and silicosis reports.

A physician-based disease surveillance system makes it possible to:

- determine the occupational disease burden in Michigan;
- identify the specific jobs, duties, and personal characteristics that put a worker at risk;
- intervene to reduce the risks and prevent disease; and
- measure the impact of interventions.

Physicians are encouraged to call (517) 353-1846 to either report an occupational disease or if they have any questions or ideas for Project SENSOR.

New technology allows doctors to "see" inside heart's blood vessels

Recent advances in technology and miniaturization have made possible a new type of ultrasound imaging system that lets doctors "see" inside the heart's blood vessels. Henry Ford Hospital's new imaging system is one of only a few in the nation.

Doctors are using the system to diagnose and evaluate atherosclerosis.

"What we're seeing with this device reminds me of the movie "Fantastic Voyage," said Fareed U. Khaja, MD, director of the Cardiac Catheterization Laboratory at Henry Ford Hospital. Science fiction fans will remember the film chronicles the adventures of a team of miniaturized doctors who take a voyage through a person's bloodstream for a firsthand look at the inner workings of the human body.

Of course, doctors can't actually travel through a person's blood vessels, but a tiny ultrasound crystal — attached to the tip of a catheter — can. The images produced by the system give a view of the tunnel-like interior of the blood vessels that's the next best thing to being there.

"It's a very promising new tool. Using this system we'll be able to get much more precise information then ever before," said cardiologist Phillip L. Kraft, MD.

The procedure, known as intravascular ultrasound, involves inserting a thin catheter into the arterial system and pushing it to the point of blockage in the artery. The ultrasound signals generated by the catheter's crystal tip are processed by a computer console and displayed on a video monitor in real time.

Currently, doctors at Henry Ford Hospital are using the ultrasound procedure to assess blockages in patients before and after balloon angioplasty. More than 400 balloon angioplasties are performed at the hospital each year. The ultrasound procedure is expected to be helpful in up to 40 percent of those cases. ■

Michigan State Medical Society

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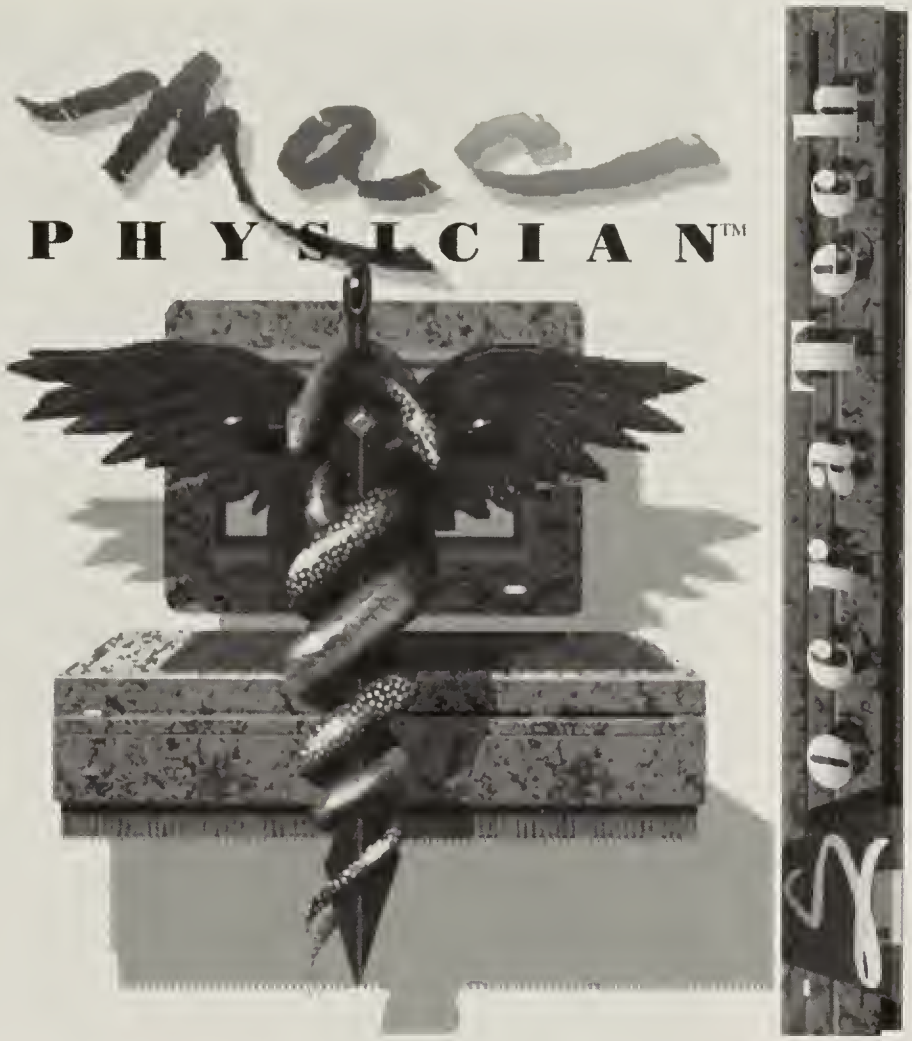

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Cover Story

SUBSTANCE ABUSE EDUCATION

Physician/lawyer teams in schools complement MSMS efforts

By Claudia Skutar

The student raised her hand and asked the two middle-aged men addressing her class if they themselves had ever tried drugs or a drink. "I've tried a drink, but I've never tried drugs," said one. "If drugs had been available when I was your age, I don't know what my choice would have been," said the other. ☞

"If drugs had been available when I was your age, I don't know what my choice would have been."

Their answers illustrate that, even a generation ago when drug use was not the widespread problem that it's become today, it was tough for kids to choose not to use them. Availability, peer pressure and role models at home of older relatives and neighbors who may drink or use drugs make it more and more difficult for children at even early ages to avoid exposure to drug abuse.

The two men speaking to the school class were American Medical Association President Alan R. Nelson, MD, and American Bar Association President L. Stanley Chauvin, Jr. The presentation was part of a 1990 pilot effort in Salt Lake City, Utah, Doctor Nelson's home town, to launch an ambitious AMA/ABA-sponsored program encouraging physicians and lawyers nationwide to team up and reach out to the youth in their local communities with their expertise on substance abuse. Both organizations feel that physicians and lawyers are uniquely qualified to share information on the medical and legal aspects of substance abuse.

"We want our professions to reach out to let students, teachers and youth workers know that we're concerned," said Doctor Nelson in a videotape on the pilot effort distributed to physicians and attorneys around the country as an aid in developing their own programs. "We must show them we care enough to give of our time and our knowledge."

Doctor Nelson explained that physicians and attorneys can engage youth in discussion about the use of alcohol and drugs and their consequences which can help them to decide not to use them.

The AMA/ABA program took root in Michigan early in 1990 after State Supreme Court Justice Dennis W. Archer attended a Los Angeles ABA meeting during which the initiative was announced. Justice Archer decided to develop a similar program in the Detroit school system, adding one component which the AMA/ABA pilot program did not have: the inclusion of law enforcement officers on the teams of physicians and lawyers. He envisioned teams of each of these professionals visiting Detroit's 156 elementary schools to talk with students about the medical and legal effects of substance abuse.

MSMS President Susan H. Adelman (left) participates in a physician/law officer/lawyer team presentation to elementary students on the consequences of substance abuse.

Justice Archer queried a number of professionals in Michigan about forging a partnership to develop this program in the Detroit schools, and it was at this point that the Michigan State Medical Society (MSMS), Wayne County Medical Society (WCMS) and Detroit Medical Society (DMS) became involved in the project.

MSMS involvement

"MSMS was very important in publicizing the program and coordinating participation in the medical community. . .and in assisting the training sessions which took place under the able leadership of James K. Johnson, MD, (president of the Detroit Medical Society)," said MSMS President Susan H. Adelman, MD.

Elementary students listen to an important message on a subject which many already know something about — that drug abuse can have serious and lasting effects.

"The program was an ambitious one. . .MSMS involvement was critical to its success."

After consultation with the schools, it was decided to target third, fourth and fifth graders, according to Justice Archer.

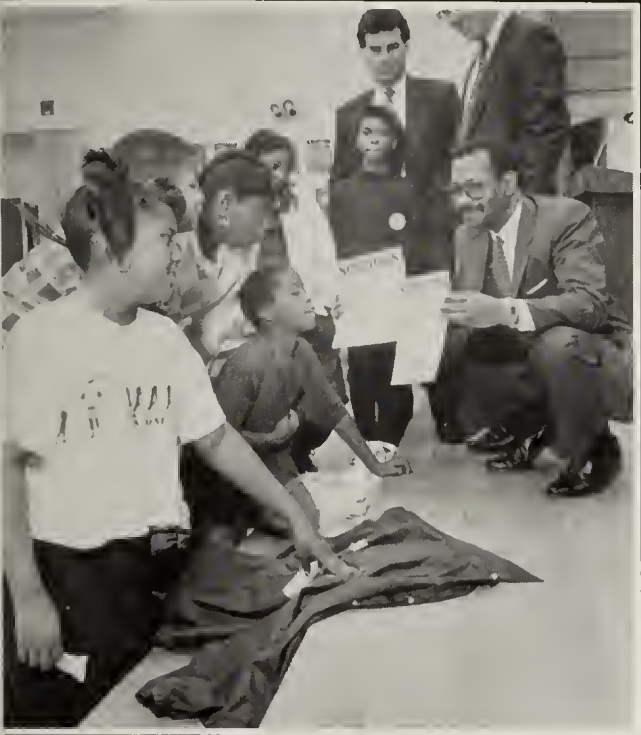
"We targeted them with the hope that we could catch them soon enough, but not so soon that they wouldn't understand the message," said Doctor Johnson.

"One reason why I felt MSMS should be involved in the program was the importance of reaching children at a young age and molding their thinking. . . to help counteract the influences which cause them to use substances," said Doctor Adelman.

The program was conducted over three successive weeks last October and November, with teams of physicians, lawyers and law enforcement officers visiting the 156 Detroit elementary schools to talk with students. The teams held an informational session with parents prior to the school presentations.

Physicians who participated in the program felt that it gave them greater insight into how serious the drug problem really is among young people.

"I think that a lot of physicians didn't realize how widespread drug use is," said John F. Fennessey, MD, immediate past president of the Wayne County Medical Society. "Going into the schools helped to raise their awareness."



Detroit Medical Society President James K. Johnson, MD, shares information with elementary students on what drugs can do to their bodies.

"It was quite shocking when I asked the students how many knew people who had been jailed or died from substance abuse or how many knew what a crack baby was like," said Doctor Adelman. "More than half of them raised their hands."

The physicians who participated also felt that it was a positive experience from a personal and professional standpoint.

"We're supposed to be a service-oriented profession," said Deborah W. Sims, MD, a general surgeon at Henry Ford Hospital in Detroit. "This is something we can do for the public. . .we need to do more. . .it's the only way we'll see changes."

Louis R. Zako, MD, a Dearborn Heights family practitioner, pointed out that a program such as this one provides physicians with the satisfaction they may not always get out of their practices.

Although physicians felt that participation in the program was a positive experience, they were concerned about the lasting effects of the message they gave to students.

"The problem is that it's a five-second message in a lifetime," said Doctor Sims. "The message needs to be repeated over and over."

"Isolated experiences in an individual's life rarely have a lasting impression while repeated experiences do," pointed out Doctor Zako. He noted that one of the strengths of this program was its repetition through three successive weeks.

Doctor Adelman said that she thought the teams were able to get their message across to the students. The program accomplished its goal "if you describe that goal as going to the schools, communicating with the kids, letting them know that we care and giving them information." Modifying behavior, explained Doctor Adelman, is a much more difficult thing to do.

Spinoff benefits

The program has had spinoff benefits, she said, in getting physicians and lawyers into the schools when they might not have otherwise visited them and in instructing them about the magnitude of the substance abuse problem.

In fact, a program encore in the Detroit schools is being planned for the fall.

"We'll keep going until there is no more drug problem," said Justice Archer.

The Oakland County Medical Society (OCMS) established a similar program in cooperation with the Oakland County Bar Association in Oakland County's schools last fall, based on the AMA/ABA initiative. OCMS solicited interested schools through a mailing, and then sent teams of physicians and lawyers into middle and high schools to speak to students about substance abuse. Interest in the program, which was conducted from October through December, was high.

"We had invitations to quite a number of schools in Oakland County," said Gertraud Wollschlaeger, MD, a professor of radiology in the Department of Radiology at Wayne State University.

The goal of the program was the same as the program offered in the Detroit elementary schools.

"We wanted to bring to children the seriousness of the consequences that follow from drug abuse. . .from a medical and legal standpoint," Doctor Wollschlaeger said.

Michael L. DeMars, MD, an addiction specialist and medical director of the Metropolitan Rehabilitation Clinics in Oak Park, said that there were so many students who asked what they could do about family members and relatives on drugs that he did a special section on it at the end of his presentation. Going into the schools created for him "more awareness of how much knowledge the kids do and don't have about drugs. . .and how widespread the problem is in schools."

As with the Detroit schools program, more sessions are being planned. A meeting has been set for March to discuss going back into the schools in April, May and June.

A slightly different approach to sending teams of physicians and lawyers in the schools was taken in Kent County, according to Susan L. Radecky, MD, program director for Family Practice Residency at St. Mary's Health Services hospital in Grand Rapids.

MSMS President Susan H. Adelman, MD, explains to Detroit elementary students the medical effects of substance abuse.

A group of five family practice residents and four Kent County attorneys visited Central High School in Grand Rapids on November 19. They developed case scenarios involving specific incidents of drug abuse and then in teams presented those cases to health education classes at the high school.

"Residents are a key vehicle in presenting the material," Doctor Radecky said. That's because they're younger, which makes it easier for the students to identify with them than with older physicians, whom the students often see as more authoritarian figures. "The students were quite responsive," she said.

The success of these presentations showed that this is an effective model to use with students, according to Doctor Radecky. It was also an effective work tool for physicians and lawyers.

"The collaboration between the physicians and the lawyers was excellent, with a lot of interaction between them, a lot of give and take," Radecky said. "They began to work together."

"Our biggest impetus was to make sure that (the students) know the facts and can make intelligent decisions about drugs," said Phil Baty, MD, a St. Mary's Health Services hospital resident who participated in the program. Doctor Baty said the group hopes that their program will serve as a pilot to be taken into more schools in the future.

MSMS President Susan H. Adelman, MD, (right) looks on while her team partner, an attorney, tells students about how using drugs can affect them legally.

Other programs

These recent initiatives in Wayne, Oakland and Kent Counties are only one part, albeit an important one, of substance abuse program efforts currently underway or in the planning stages in Michigan. A coalition of state departments and agencies provides schools statewide with the Michigan Model for Comprehensive School Health Education, a program containing a number of health education components, including instruction on substance abuse.

An eager group of students gathers around Detroit Medical Society President James K. Johnson, MD, as he uses a prop to make a point about the dangers of substance abuse.

Several Michigan law enforcement groups, including the Michigan Department of State Police, offer schools Project D.A.R.E., a semester-long curriculum aimed at teaching students not just the facts about substance abuse, but enhanced self-esteem and decision-making skills. The national program was developed in 1983 by the Los Angeles Police Department.

Within this context, Doctor Adelman chose to make discussion and education about the problem of substance abuse a focal point of her MSMS presidency. While still president-elect in 1989, Doctor Adelman spearheaded the formation of the MSMS Focus Group on Chemical Dependency as a forum for examining substance abuse problems in Michigan.

The focus group determined its first priorities were "physician education, medical student education and school education," according to Doctor Adelman.

Toward that end, the focus group established the Task Force on Physician Education late last fall.

"We need to develop an organized approach to educating physicians on diagnosis, treatment and proper referral of patients with chemical dependency," she said. "Most physicians don't have a real academic knowledge about this area."

The focus group also developed the Task Force on School Education. Although it just held its initial organizational meeting in early January, the task force already has made contact with 200 Michigan schools about providing resources to complement current substance abuse programs in the schools or to aid in developing new ones. To date the task force has received about 60 positive responses.

"There's no use trying to reinvent the wheel," said Suzanne H. Pederson, past president of the MSMS Auxiliary and chairperson of the task force. "There are already many viable programs in place in some school districts while in others there may be none." Pederson said the task force plans to tailor its help to the particular needs of the school districts.

The point of these efforts, said Doctor Adelman, is to develop a strategy and "impact in a positive way the substance abuse problems of our state."

As Pederson put it in describing MSMS efforts to aid school districts with substance abuse resources, "we'll offer whatever it takes." ■

Claudia Skutar is communications specialist for MSMS.

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
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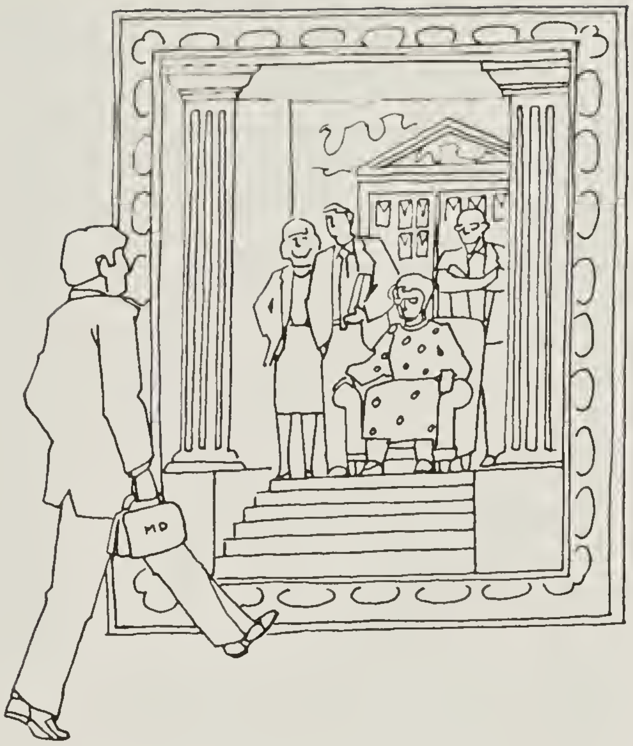


PHYSICIANS, GUARDIANSHIPS AND THE COURTS

By Hon. John N. Kirkendall

Announcements proclaiming an aging society are no longer greeted with astonishment. It has become commonplace to accept the notion that the over-80 age group is the fastest growing age group in the country. Spin-offs from this phenomenon are being felt in all institutions of society, including the courts. The courts are receiving increasing numbers of guardianship petitions for older persons. And when older persons find themselves the subject of a guardianship petition, there usually is, or should be, a physician in the picture somewhere.

What the physician should be able to expect from the courts in such cases and what the courts should be able to expect from the physician is the subject of this article.

A person must be "legally incapacitated" before a guardian may be appointed. Michigan law provides that such legal incapacity is determined by a probate judge or jury based upon clear and convincing evidence. Legal incapacity is a legal term of art. It means that the person "lacks sufficient understanding or capacity to make or communicate informed decisions concerning his or her person." The statute points out that this incapacity may arise from mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication or other cause. The statute does not permit old age to be considered as a basis for the appointment of a guardian. (None of this discussion relates to a person who is developmentally disabled. A quite different statute applies for guardianships for developmentally disabled persons.)

In cases where the court determines that a guardianship is appropriate, the law requires the court to appoint a limited guardian wherever possible. A limited guardian is one that has some, but not all, powers over another person. A full guardian is only appropriate where an individual is totally without capacity to care for himself or herself. This is important information for you, the physician, to know: as the care giver for an individual, you may be in a good position to know what the older person is able to do and what the person is unable to do. For example, such a person may be able to determine where he or she should live but may not be able to make informed decisions concerning medical treatment. If that is the case, the guardian should not be given the power to make placement decisions but only to make medical decisions. The gerontologists among you have been telling the legal community that to grant unnecessary powers of one person over another speeds the aging process.

The initial physician's letter

In many cases, your first and only contact with the court in guardianship cases will be the mere writing of a letter explaining to the court why a guardianship is being sought. This is particularly true when the guardianship case is uncontested. When Mom is in the hospital and is awaiting transfer to a placement outside her former home, if she is legally incapacitated and has not executed a durable power of attorney while competent, it may well be that a guardian should be appointed to explore options and contract for post hospitalization care. In many such cases, family members and Mom agree upon the desirability of the guardianship and the identity of the person to serve as guardian. In such a case, the court will wish to be assured of Mom's diagnosis and the state of her cognitive functioning before appointing a guardian. A physician will be sought to present a letter to the court. However, the contents of the letter should be something more than, "Mom is now incompetent and needs a guardian."

Contents of the physician's letter to the court

The court at the hearing must find facts upon which to make two decisions. The first is whether there is a legal basis for the

Continued on next page

Continued from previous page

guardianship. If there is such a basis, the second decision the court will make is whether and how the guardian's powers should be limited. As the physician, your letter to the court can be very helpful to your patient and to the court.

The letter should contain the following:

1. A description of the physical and psychological infirmities of the person, and a diagnosis, if possible.

2. An explanation of how and to what extent any infirmities interfere with the ability of the person to receive or evaluate information in making decisions.

3. The decisions or types of decisions that must now be made on the person's behalf. (In other words, why is it necessary to have a guardian at this time?)

4. The decisions or types of decisions that the person continues to be able to make for himself or herself.

5. A list of medications the person is receiving, the dosages, and a description of the effects each medication has upon the person's behavior.

6. Prognosis for improvement.

7. Recommendation for most appropriate rehabilitation plan.

8. Any further observations or recommendations you feel will assist the court in arriving at a just conclusion.

Sometimes more than a letter is required

There are two occasions when a letter just won't do the trick. These occasions do not arise often. And even when they arise, there may be alternatives to a court appearance that may be employed.

If a guardianship case is contested and if the attorney for the older person wishes to cross examine the physician that prepared the letter to the court, the physician may be subpoenaed to appear in court so that bases for the opinions can be set forth and examined by the attorney for the older person.

Second, there is a procedure by which the older person may request an independent examination by a physician or a mental health professional. If you agree to serve as a mental health professional in a given case and perform an examination, you must file a "Report of Physician/Mental Health Professional of Alleged Legally Incapacitated Person" within five days of the date of hearing and be subject to subpoena in the event anyone wishes to cross examine you on the report.

How to avoid coming to court at all

I have indicated that there is a possible alternative to a court appearance in these last two situations. It is possible that a deposition can be taken of you in your office at your convenience with a court reporter present. In the event the older person's estate is insufficient to warrant payment for such depositions, a service may be available to help. A state association of court reporters has offered their services in a pro bono project for the State Bar of Michigan. It is possible that this program could be working in your area so that the services of the court reporter for such a deposition could be provided free. It is worth checking on. If you are faced with this situation, you may call the Office of Services to the Aging (517) 363-8187 in Lansing to find out about the availability of this program.

If all else fails, and the physician must go to court

When a subpoena arrives in your office, your office staff must know that this document deserves immediate priority. It is not a mere "invitation." It must not be filed or placed in the wastebasket.

Most courts will value a physician's time. Most judges have been practicing attorneys and they realize the importance of spending time in the office in order to pay the bills. On the other hand, courts will be protective of their role in society. Courts will not permit one person's access to the judicial system to be thwarted by those who ignore the lawful documents of the court. Keeping all this in mind, once you receive a subpoena, work with the attorney's office who generated the subpoena to see if you can arrange a specific time to appear in court. That way, you can schedule an appearance at a certain time. You can be in and out within the scheduled time. If that is not possible, work with the attorney to see if a deposition can be scheduled at a time and place convenient for all parties. If that does not work, it may be necessary for you to either speak directly to your attorney or call the court directly. It is important to have cooperation among the lawyers, the physicians and the judiciary in guardianship cases. Those we serve will be enormously benefited.

Other tips about guardianship proceedings

There is additional information about guardianship proceedings that you may find useful.

1. Any person interested in the welfare of another may file a petition for the appointment of a guardian.

2. If the older person already has signed a durable power of attorney when competent, it is very likely that a guardianship proceeding is not necessary.

3. The older person's choice of who should serve as guardian is very important.

4. A hearing can be set up within three to four weeks (six weeks in Wayne County). Outside of Wayne County, a temporary guardianship can be in place in an emergency situation in anywhere from a few hours to a few days. If you have an emergency, immediately contact the probate register in your county to find out the procedure.

5. There is no filing fee for the appointment of a guardian or for the appointment of a temporary guardian. There may be a fee for the investigation and report that is filed by the guardian ad litem appointed by the court. A guardian ad litem is an attorney appointed by the court to investigate the facts and make a recommendation to the court on the date of the hearing. You may wish to find out who this person is so that you can talk with him or her so that the report can take into consideration the information you have about the older person.

6. The guardianship hearing itself may be closed to the public upon request by the older person.

7. The older person will be given an attorney, at state expense if necessary, if any of these conditions exist: the older person requests an attorney, the guardian ad litem requests an attorney, the older person contests the guardianship, the older person requests the powers of the guardian to be limited, or the older person objects to a particular person serving as the guardian. A jury trial may be requested by the older person.

8. The older person may request an independent evaluation by a physician or mental health professional or the court may order it.

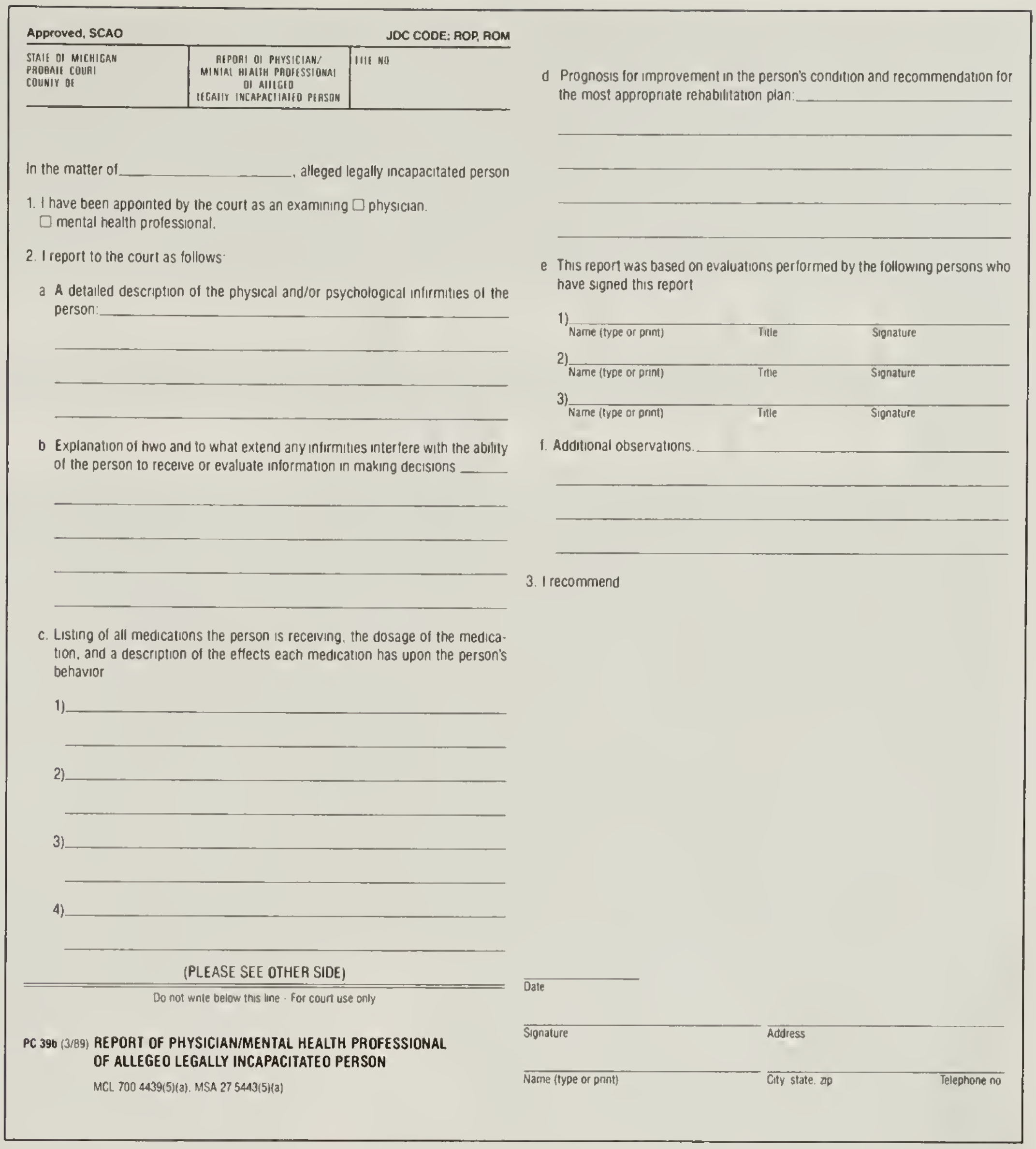
9. The older person may request the hearing to be held some place other than in the courtroom. This may be helpful to know if you have a patient who wishes to be present and is unable to attend a hearing outside the home or the hospital.

Conclusion

The physician is an integral part of the guardianship process for older persons. At the very least, the physician could write a letter advising the court as to the bases and necessity for the guardianship and what duties the guardian should perform. In addition, at the request of the court, the physician could prepare an independent medical report on a court form. Further, the physician could be called upon to give testimony either in court or through a deposition.

The courts appreciate the value of the physician's professional opinions and will strive to accommodate the physician's schedule in setting hearings at which the physician is to testify. ■

John Kirkendall is probate judge, Washtenaw County Probate Court.



Approved, SCAO **JDC CODE: ROP, ROM**

STATE OF MICHIGAN PROBATE COURT COUNTY OF	REPORT OF PHYSICIAN/ MENTAL HEALTH PROFESSIONAL OF ALLEGED LEGALLY INCAPACITATED PERSON	FILE NO

In the matter of________________, alleged legally incapacitated person

1. I have been appointed by the court as an examining ☐ physician.
   ☐ mental health professional.

2. I report to the court as follows:

   a. A detailed description of the physical and/or psychological infirmities of the person:________________

   b. Explanation of hwo and to what extend any infirmities interfere with the ability of the person to receive or evaluate information in making decisions ________

   c. Listing of all medications the person is receiving, the dosage of the medication, and a description of the effects each medication has upon the person's behavior

      1)________________

      2)________________

      3)________________

      4)________________

(PLEASE SEE OTHER SIDE)

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PC 39b (3/89) **REPORT OF PHYSICIAN/MENTAL HEALTH PROFESSIONAL OF ALLEGED LEGALLY INCAPACITATED PERSON**

MCL 700.4439(5)(a), MSA 27.5443(5)(a)

   d. Prognosis for improvement in the person's condition and recommendation for the most appropriate rehabilitation plan:________________

   e. This report was based on evaluations performed by the following persons who have signed this report

      1)________________
      Name (type or print) Title Signature

      2)________________
      Name (type or print) Title Signature

      3)________________
      Name (type or print) Title Signature

   f. Additional observations:________________

3. I recommend

Date

Signature Address

Name (type or print) City, state, zip Telephone no

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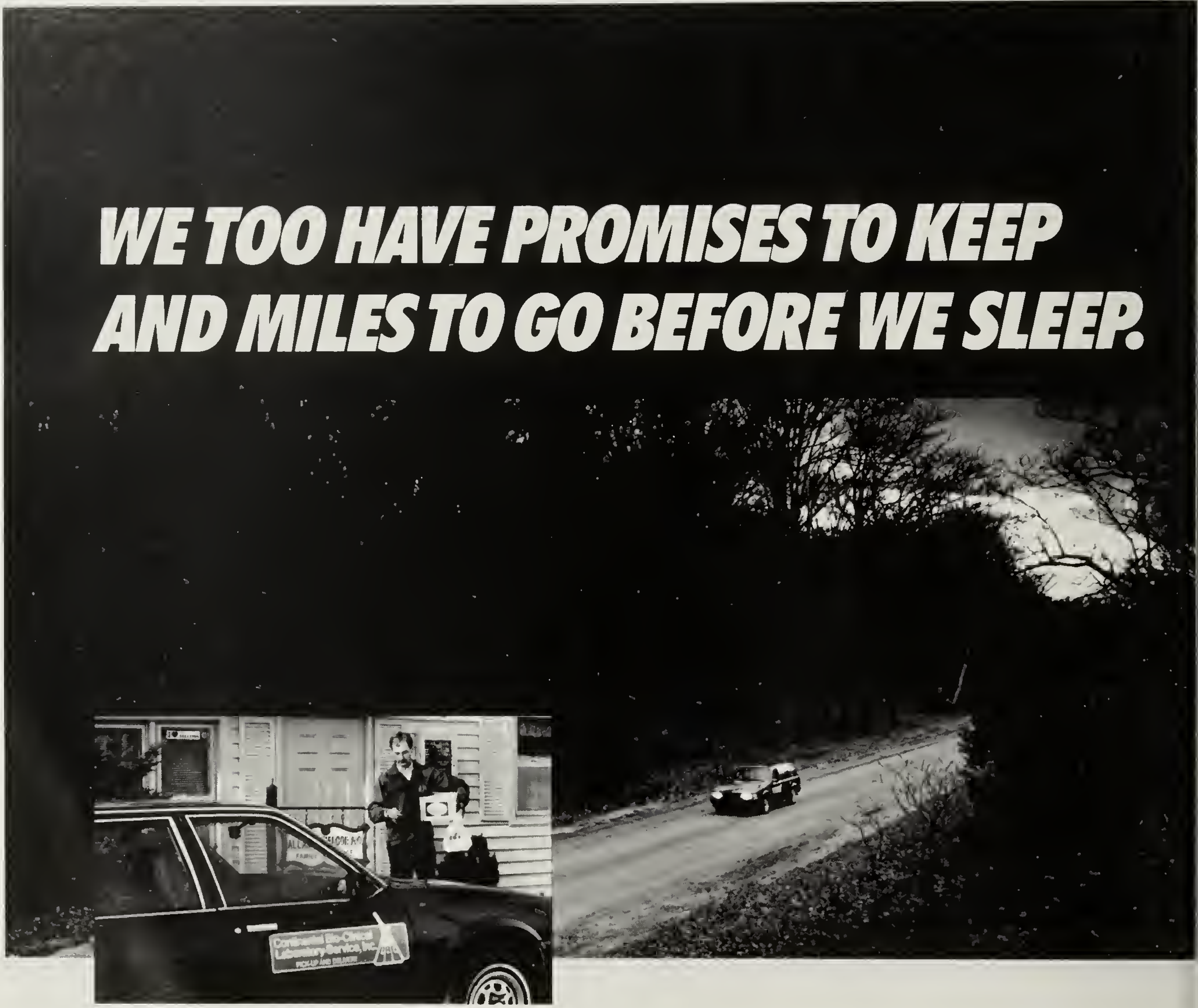
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Practice Management

How to unsnarl appointments

By George S. Conomikes

Every day most Americans go to work with some sort of schedule. Bricklayers know that they will lay between 400 and 600 bricks; truck drivers will log 300 miles; salespeople will make a certain number of calls; and executives will put out a predictable number of fires.

But the lonely physician doesn't know what's in store for him/her. He or she just hopes today is not going to be as bad as yesterday...and these hopes are usually shattered.

Of all the complaints we hear from all concerned parties...physicians, medical assistants, nurses, patients, and even the relatives and friends of all the foregoing...the doctor's appointment schedule heads the list.

In surveys of practice management problems which we've undertaken with thousands of physicians and their office staffs, appointment scheduling comes out either ahead of, or just behind, the telephone as the bane of the practice.

One reason for the appointment-scheduling problems is the telephone. If the phone is too busy, improperly staffed, or calls are not handled systematically, then it's tough to run a good appointment-scheduling system.

Depending upon your specialty and your communication patterns with patients (i.e., encouraging or inhibiting routine patient phone calls), anywhere from 40 percent to 70 percent of incoming phone calls result in an appointment. Therefore, the most important ingredient in a good scheduling system is a telephone system that helps you determine the urgency of the calling patient's problem.

Well-organized practices don't leave this to chance and don't rely on the memory pattern of the telephone receptionist. After all, on a busy Monday or Friday afternoon, he/she could be so preoccupied and tired that his/her computer-bank mind draws a blank.

The way to help yourself, and your telephone receptionist, is to develop a list of patients' problems by levels of urgency:

Emergencies (define them): What should be done with the patient?

Urgencies (define them): When should the patient be seen?

Routines (define them): When should the patient be seen?

Just about everyone knows what an emergency is and what to do about it, and just about everyone knows what a routine is and what to do about it.

But what we have found is that your appointment book is filled up with routine appointments, and this is what keeps out your sick and urgent patients.

When physicians and their medical assistants tell me that the doctors are booked the next three weeks, or six weeks, or nine weeks, then I can only respond by saying that they are hurting themselves...because the next three, six, or nine weeks a significant number of patients are going to be just plain sick...not emergencies, just plain sick.

These sick patients who need to be seen relatively soon are the ones who have to fight to get in.

Why? Because nobody has kept the data on what your work-in rate is. By asking your appointment scheduler (who may also be your telephone receptionist) to keep tabs on your emergencies and your urgencies (sick patients), you could learn with some reasonable accuracy how may "openings" to keep in your appointment scheduling system.

The openings are for your predictable three, four, five, or ten emergencies and urgencies that have to be worked in every day.

Your receptionist tells me the biggest appointment-scheduling problems are the emergencies and those sick patients who are unwilling to wait. Physicians tell me that their most interesting patients are those emergencies and those sick patients, not the routine "well" patients. So your routine well patients and your appointment scheduler are working at odds.

Solution:

Get the data on work-ins. Open up your filled-up appointment book. But set the rules with your appointment scheduler. He/she wants you to set the rules. If you don't work with her/him on it, you have no control over your day's work. And tomorrow will be like today. And you'll envy the bricklayer, the truck driver, and the salesman, and everybody else when they, in fact, envy you because they don't know your scheduling nightmare. ■

George Conomikes is considered a leading authority on practice management. He is editor and publisher of Conomikes Reports, and the author of a book entitled Practice Management Techniques. This article was provided compliments of Physician Service Group Inc., an MSMS subsidiary.

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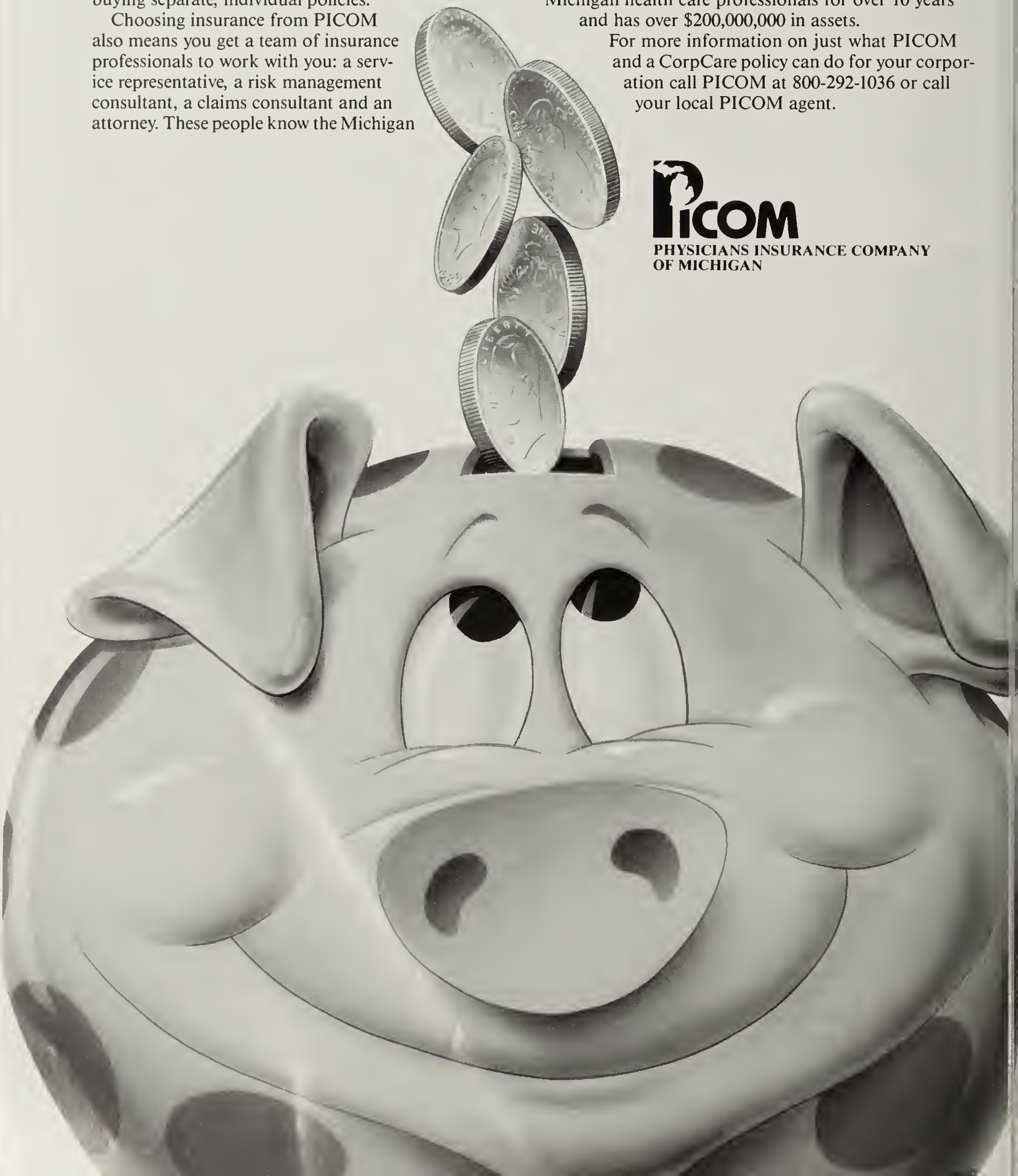
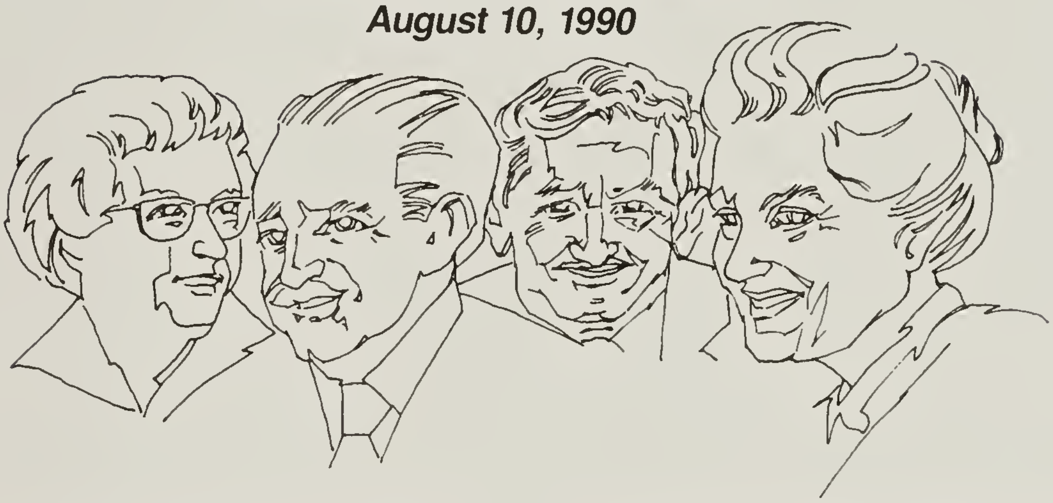


Prescription Drugs and Older Consumers

Report of the Governor's Task Force on Prescription Drugs and Older Consumers Issued August 10, 1990



In 1988, Governor Blanchard appointed a Task Force to prepare recommendations for helping older adults control the cost of their pharmaceutical medicine as well as improve their compliance with their prescriptive drug therapies.

This Task Force was convened under the joint leadership of the Michigan Office of Services to the Aging and the Michigan State Medical Society. Director Olivia Maynard and James O'Brien, MD, served as co-chairs. Representatives of the nursing home industry, the hospital community, the pharmacy and medical professions were joined in this Task Force by members of the academic community, by senior advocates from the American Association of Retired Persons and the Michigan Council of Senior Citizens and by consumer advocates from the general public.

In preparation for its work here in Michigan, the Task Force reviewed literature and findings from around the country in this issue area. Much of what the Task Force found is echoed in the summary of The Surgeon General's Workshop on Health Promotion and Aging which reports:

> Most (60 percent) of adverse drug reactions from drugs are pharmacologic and many of these may be preventable with more careful prescribing, monitoring and patient education.
>
> Elderly patients have a higher risk for developing adverse drug reactions than do persons in the general population (40 percent of all people suffering adverse drug reactions are over age 60); use of multiple drugs may be the strongest of several factors that predispose older persons to this excess risk;
>
> Noncompliance with prescribed drug regimens appears to be associated more with the number of drugs taken than with increasing patient age.

Noncompliance for whatever reason can lead to disastrous results. According to the Inspector General of the Department of Health and Human Services:

> Adverse Drug Reactions caused 243,000 older adults to be hospitalized in 1985. Although Americans age 60 and over comprise only 12 percent of the total US population, they account for 39 percent of all hospitalizations and 51 percent of deaths from drug reactions.
>
> Drug induced falls produce 32,000 hip fractures each year.
>
> Serious mental impairment caused or worsened by medication affects 163,000 older Americans.
>
> 61,000 older people manifest symptoms that mimic Parkinson's disease due to prescribing of anti-psychotic medications.
>
> Patients, families, public and private health insurers pay an estimated $4.5 to $7 billion a year for health care the elderly need to combat adverse drug reactions.

The National Council on Patient Information and Education reports that one sixth of all hospital admissions of patients are the result of adverse drug reactions. It is estimated that these hospitalizations cost $21 billion a year.

It is from within this context that the Task Force set out to prepare recommendations for older consumers, their caregivers, the health care profession and the public. Proper compliance with medication regimens is not only good for the patients financial and physical well being, it is sound public policy in a cost conscious age.

The Office of Services to the aging shall monitor the implementation of these recommendations through an oversight committee made up of a representative of the Michigan State Medical Society, the Michigan Pharmacists Association, the American Association of Retired Persons and the Michigan Commission on Services to the Aging and shall report annually progress made toward implementation.

It is the recommendation of the task force that each of the constituent groups undertakes the development of an action plan to ensure the implementation of the recommendations.

The Michigan State Medical Society shall develop the action plan for the implementation of those recommendations which have an impact on the provider community.

The Michigan Pharmacists Association shall develop the action plan for the implementation of those recommendations which have an impact on the provider community.

The American Association of Retired Persons and the Michigan Commission on Services to the Aging shall develop the action plan for the implementation of those recommendations which haven an impact on the older consumer.

Recommendations appear on pages 28, 29, 30 and 31.

The Recommendations

Communication

The quality of communication between a physician or other provider and the patient will determine whether that patient understands and uses prescription drugs properly. Prescriptions are often made at times of stress or when the patient is distracted by an unfamiliar situation. The following recommendations are intended to improve the quality of communication.

1. *Establish as a communication aid a statewide "patient portable data base" which could take a variety of forms:*
   - a. *A "Passport" type booklet*
   - b. *A single comprehensive form which would include all relevant information regarding a person's prescribed drugs*
   - c. *A little spiral notebook in which could be noted the prescription drugs as well as other vital health indicators such as blood pressure, etc.*
2. *Promote the recording of complete health and medication histories as a part of all health care for older people.*
3. *Distribute and encourage the use of health and medication records to be kept in the possession of the consumers, e.g., medication "passports" or AARP's publication "Getting the Most from your Medication."*
4. *Develop and utilize communication aids that make it easier for older people to discuss medication questions and instructions with their health care providers, for example, a wallet card with medication-related questions for patients to ask their health professionals.*
5. *Develop a checklist of relevant information that patients should tell their doctors (e.g., new symptoms that could be medication side effects, problems in following the medication regimen).*
6. *Conduct or stimulate research about communication practices between providers and older patients regarding medication, including those in the long-term health care setting.*
7. *Advocate policies among the aging network organizations that promote improved patient-provider communication.*
8. *Develop and promote group education and support programs to supplement patient-provider communication about medications and compliance with the prescribed regimen.*
9. *Develop tools, such as patient education guidelines, to help health professionals communicate with patients about medications.*
10. *Develop role playing situations or opportunities for videotaping interactions between health profession students and older patients, focusing on conveying appropriate communication skills and overcoming stereotypes. Validate actual improved health effects.*
11. *Provide funds to study communication problems, particularly those that test the effectiveness of different communication skills or interventions and assess older patients' specific needs for medication information.*
12. *Identify or develop media materials, designed for use by visually or auditory-impaired individuals, to provide older adults with information about prescription drugs and enable them to communicate more effectively with health care providers.*
13. *Encourage older persons and their caregivers to ask for written or visual instructions, in addition to oral directions on the proper use of prescribed medicines and over-the-counter drugs.*
14. *Encourage older persons to ask physicians and pharmacists about their prescription and over-the-counter drugs, including information about how to evaluate whether or not the medication is working properly.*
15. *Explore reimbursement systems to encourage prescribers and pharmacists to provide medication counseling.*
16. *Raise awareness about the value of communication in promoting compliance with prescribed drug regimens and providing high quality medical care.*
17. *Encourage health professionals to provide written and/or audio visual information as well as oral counseling.*
18. *Raise awareness about the documented reluctance of certain patients to ask questions and the need for health professionals to provide more information spontaneously.*
19. *Educate health professionals in nonverbal communication skills which evidence shows are important and can be taught.*
20. *Encourage research in the area of patient-provider relationships and communication (not just with the prescriber).*
21. *Conduct studies to determine the effect of good patient-provider communication on the incidence of adverse consequence of drug misuse and the incidence of malpractice suits.*
22. *Translate to health professionals the impact of poor communication into real economic terms, and promote the economic benefits to medical practice of communicating well with patients. Use vehicles such as practice management courses and articles in appropriate health journals.*
23. *Emphasize the value to the provider of furnishing complete verbal and written or audiovisual instructions in attracting and retaining older patients.*
24. *Encourage practitioners to provide medication record forms to older patients, to add each new prescription to the record, and to counsel patients about the need to show the record to every physician and pharmacist they see.*
25. *Promote the role of pharmacists in keeping records of patient prescription from multiple physicians and in helping patients to recognize and avoid potential adverse drug interactions.*
26. *Raise awareness about the benefits that a patient's involvement can have on his or her own health care relative to compliance.*
27. *Develop "how-to" materials for professionals that can help them promote patient involvement (e.g., now to organize a patient advisory group).*
28. *Work with health professional students to promote effective communication with patients and families.*
29. *Promote the use of patient-provider contracts and other potential mechanisms for enhancing patient responsibility for their health care.*

Compliance

Even assuming that good information about prescriptions is given initially, problems with compliance in the use of drugs still arise. This set of recommendations addresses areas of interference with instructions which impede compliance.

1. Develop or promote systems for monitoring drug taking to ensure up-to-date knowledge about current medication use (including over-the-counter drugs) and past drug-drug or drug-food interactions.

2. Develop and promote compliance aids for older people.

3. Make new and existing compliance aids widely available to older people and their physicians, and advocate physician use of the products, which have been shown to enhance compliance.

4. Develop innovative compliance aids for older people, such as the new, inex-

pensive silicon "timer" chip. Programmed easily and inserted in a medication bottle cap, the chip beeps when it is time to take the medication.

5. *Perform or promote research on the drug-taking and compliance behavior of older Americans and on behavior modification techniques specific to this population.*

6. *Develop more single-dose and combination medicines for conditions common to older people. Simplified regimens have been shown to increase compliance.*

7. *Encourage the use of a system in clinic situations that allows the patient a primary physician or care coordinator. This has been shown to enhance compliance.*

8. *Develop support systems for medication-taking for older people with physical disabilities or memory loss.*

9. *Develop social support systems that enhance compliance, such as telephone reminder programs, volunteer in-home assistance, or scheduling aids designed for supportive caregivers at home or for workers in adult day-care settings.*

10. *Develop workable compliance-monitoring systems that alert practitioners to non-adherence. These may involve testing for levels of a drug in the body or interactive record keeping with patients. Research shows that physicians overestimate the extent of compliance in their own practices and have little success in predicting which patients will not comply.*

11. *Develop and publicize profiles of deliberate noncompliance by the elderly that will help practitioners identify such behaviors among their patients.*

12. *Develop or promote aids that overcome physical barriers to compliance (e.g., labels with large print; easy-to-handle compartments for organizing a full day's multiple capsules in advance).*

13. *Develop assessment tools to identify problems of over or under-use of medicine. Such a tool should take into account dietary, activity and other lifestyle issues to create a comprehensive, yet manageable record.*

14. *Develop programs to improve the elderly-specific interpersonal and adherence-promotion skills of practitioners.*

15. *Inform providers of the increased susceptibility of elderly people to altered drug actions.*

16. *Raise awareness of compliance issues among providers and consumers and promote the use of nonverbal compliance aids.*

17. *Raise awareness among providers and consumers about common forms of deliberate non-compliance.*

18. *Raise provider awareness of the kinds of information that may help older patients to take their medicines properly.*

19. *Develop messages that explain the benefits to compliance of prescribing drugs with simple regimens (e.g., one pill once a day) whenever possible.*

Coordination/Cooperation

Coordination and cooperation between the different caregivers in the health professions will contribute to more effective treatment for a patient and satisfaction with the care. This is particularly true if specific drug regimens are to be effective. Often a patient transfers from one specialist to another or is moved from one facility to another. Cooperation is particularly significant when there is an unstable physical condition which requires medications that need re-evaluation. These recommendations address the issues of coordination and cooperation.

1. *Develop cooperative training arrangements for health professional students with geriatric clinics, retirement facility medical programs, and other elderly-specific medical institutions that treat the non-institutionalized older population.*
2. *Promote health care team practices and encourage development of new roles for some health care providers (e.g. consultant pharmacist and geriatric nurse practitioners). Reimbursement schemes to provide payment for the utilization of these new services are also required.*
3. *Promote greater communication among practitioners such that various professionals cooperate in the care of a particular patient in order to minimize the fragmentation of care.*
4. *Communicate the need for community-based providers to coordinate their medication (and other) care.*
5. *Promote a coordinated interdisciplinary team approach within a single care facility or the community as a whole.*
6. *Encourage collaboration among health providers.*
7. *Disseminate information on the adverse effects on health outcomes, malpractice risk, and practice growth that can occur when health care providers fail to communicate among themselves about the different medicines they prescribe for the same patient. Report the positive results of innovative approaches to overcoming this barrier.*
8. *Develop and stimulate community-wide or institutional coordination mechanisms among primary care physicians and the specialists to whom they refer older patients, including dentists.*
9. *Promote the use of Geriatric Assessment/Evaluation Units or teams to carefully evaluate an elderly person with multiple problems.*

Geriatrics/Professional Education

The growth of geriatrics as a specialty is key if the medication problems of the elderly are to be solved. Central to that growth is the educational dissemination of the principles of geriatrics, i.e., an understanding of the elderly person as patient. All health care professionals need training and experience in geriatrics during both their initial and continuing education. Geriatric education must be targeted to those who certify health professionals.

Professional education should also include the development of new health care roles, such as consultant pharmacists and geriatric nurse practitioners.

1. *Encourage the implementation of these recommendations by those groups who educate health care professionals, including those responsible for continuing education programs.*
2. *Educate those who are responsible for the certification and licensure of health professionals in the principles contained in these recommendation.*
3. *Include positive experiences with older people in the education and training of health professionals.*
4. *Improve the geriatric education of health professionals.*
5. *Enhance the image of geriatrics as a medical specialty.*
6. *Develop rotations in geriatrics during health professional education. Feature community interaction with senior centers, senior nutrition programs, or senior residence facilities for health screening or health education opportunities.*
7. *Develop continuing education programs to help health professionals keep up with new drugs and current prescribing practices related to older patients.*
8. *Provide funding for expanded health professions school curricula in geriatrics, including altered drug action, recommended prescribing and dispensing practices, and patient education.*
9. *Conduct and publicize research that identifies the kinds of geriatric health professional education available as well as the areas in need of improvement in existing programs.*
10. *Provide funding for geriatric chairs at health professional schools and other ways of attracting high quality faculty and enhancing the image of the specialty of geriatrics for health profession-*

al students.

11. Promote professional self-assessment of attitudes about older patients.
12. Educate professionals to counsel older people about overcoming physical as well as financial barriers.

Information for Older Persons

Better knowledge of prescription and non-prescription medications by older persons can bring about greater responsibility in their use and promote better general well being. The major need is to encourage the consumer to be more assertive in seeking out information.

1. Encourage medication use surveys by older consumers to evaluate available pharmacy services in their communities and to establish comparative data on generic and proprietary drug costs.

2. Encourage the use of "brown bag" drug information programs through the aging network whereby older persons can bring their current medicines in for an impartial evaluation by a pharmacist.

3. Provide or promote available resources for understandable written drug information for older people.

4. Ensure cost effectiveness and quality assurance when ordering prescription drugs by mail.

5. Involve Area Agencies on Aging and local aging service providers in the dissemination of prescription drug information.

Professionals

This group of recommendations address the responsibility of health professionals to develop and maintain their skills in the treatment of the elderly with prescription drugs. Specific mechanisms are called for to ensure positive outcomes of drug action in the elderly.

1. Improve and disseminate the base of scientific information regarding the specific mechanisms and outcomes of drug action in the elderly.

2. Develop prescribing aids and guidelines for physicians to use in individualizing therapy, such as creating an "elderly dose" that differentiates from "normal" does, and develop better procedures for measuring drug actions and interactions in individuals. Utilize computer programs to aid the prescriber in identifying the likely interactions and side effects of various multiple drug combinations.

3. Promote awareness of the extent of multiple drug use.

4. Change physician's attitudes about both the problem of over medication and under medication.

5. Educate physicians about the benefits of simplified drug regimens.

6. Educate health care professionals about common symptoms produced by interactions of prescription and nonprescription medications as well as the common nuisance side effects and the symptoms or signs of more serious side effects.

7. Educate physicians, other prescribers and pharmacists about ineffective medications.

8. Encourage re-examination of prescribing habits through the use of the FDA's list of Questionably Efficacious Products and similar lists. Ensure continued up-dating of the lists.

9. Promote the use of a thorough medication history and a medication profile.

10. Encourage and educate physicians and pharmacists about the importance of including nonprescription and social drug information in the medical chart and medication profile.

11. Encourage physicians to consider individualizing drug therapy for the elderly.

12. Educate physicians and pharmacists about pharmacodynamic and pharmacokinetics changes in drugs and the related physiologic mechanisms.

13. Promote careful monitoring of drug therapy.

14. Encourage the use of non-physician providers, such as nurses or pharmacists, to evaluate individuals who seem stable and need medication refills. This practice will allow less cost to the consumer while providing for more frequent health professional contact. A new role for the dispensing pharmacist could be an evaluation (via protocol) of patients who request medication refills.

15. Develop programs to improve elderly-specific drug counseling skills.

16. Raise awareness among health professionals about the positive effects of adequate time spent counseling the older patient regarding medication.

17. Raise awareness about common forms of deliberate noncompliance.

18. Develop an "Ask Your Patient" campaign to encourage health professionals, especially physicians, to question older patients about the medicines they take before prescribing any new drug.

19. Develop messages that alert professionals to potential self-medication among older people (e.g., sharing drugs, using "leftover" pills, taking over-the-counter medications).

20. Emphasize to physicians the role that all health professionals can play in teaching older patients to keep medication records and perform other responsibilities. For example, suggest delegation of medication history taking to nurses or physician assistants in clinic and practice settings.

21. Encourage physicians, pharmacists, nurses, and other health providers to monitor older patients especially closely to determine whether the dose prescribed is having the desired effect. Emphasize that individuals vary in their responses and that individualization of dosages is necessary.

22. Identify medicines that are over-prescribed or inappropriately prescribed for older people, and alert health professionals about these trends.

Psychotropics/Long Term Care/De-Institutionalization

The frail elderly with chronic illnesses who are dependent are particularly vulnerable to overuse or misuse of prescription drugs. Drugs seem oftentimes to be prescribed for the convenience of an institution or caregiver. While recognizing the controversial nature of the issues surrounding drug use in long term care settings, these recommendations are intended to ensure new approaches and greater safeguards for the consumer.

1. *Improve de-institutionalization procedures that often leave older people confused about additional or different medicines and providers.*
2. *Protect the patient in long-term care facilities from inappropriate drug use (unnecessary medication, inappropriate dosage, uneconomical selection of product) by close monitoring of medication regimens.*
3. *Monitor the effect of the enforcement of the Medicare and Medicaid standards of practice relating to drug use and restraints in the nursing home.*
4. *Educate older consumers and their caregivers about the risks of and alternatives to psychoactive medication use by older adults.*
5. *Develop and publicize alternative approaches (counseling, activity, dietary programs) which can reduce reliance on medication in depression, insomnia, Type II diabetes, arthritis, hypertension, or anxiety.*
6. *Reduce antipsychotic drug use in nursing homes. Administer antipsychotic*

drugs only when there is a specified psychiatric disorder and not specifically for restraint, uncooperativeness or verbalizations. The drugs should not be administered on a PRN basis.

7. *Ensure psychiatric or geriatric attendance and diagnostic charting for renewal if more than one psychoactive drugs is prescribed.*
8. *Require monthly renewal of PRN order for psychoactive drugs with updated diagnostic evaluation by attending physician.*
9. *Encourage geriatric appropriate doses for psychoactive drugs and limit PRN orders to these levels.*
10. *Ensure that a consulting pharmacist providing services to an institution is not affiliated in any manner with the vendor of pharmaceuticals or a supplier of pharmaceuticals to the institution. Fair compensation should be provided to a pharmacist for consulting services to an institution.*

Research/Publication

In order to develop research programs and publications regarding the problems of drug use among the elderly, these Task Force recommendations need to be publicized in journals and papers of professional organizations.

1. *Conduct age-specific studies about the nature, causes, outcomes, and prevalence of adverse drug reactions and interactions.*
2. *Develop and disseminate a risk profile to aid in predicting which older individuals are at highest risk of having adverse drug reactions or drug-induced illness.*
3. *Identify and publicize related research needs and opportunities in health education and public health professional journals.*
4. *Undertake a study of the impact of fragmentation of the health care field and its impact on pharmacological therapy.*
5. *Use state and county level health professional organizations to promote the use of these types of materials. Also encourage use of materials which are based upon the USP dispensing information in order to facilitate a consistent message (e.g. the PEP program which Michigan Pharmacists Association makes available to members or the DUET program from the Academy of Family Practice). Suggest all professional journals have an article on this within the next year.*
6. *Create a brochure which lists these types of information sources including the content of the audio visual materials.*
7. *Develop articles for professional journals, presentations for meetings of professional societies and hospital staffs, and direct-mail messages on this topic. Describe the consequences that poor patient-provider communication has on business and on health. The task force may want to suggest that the journals of the individual state professional associations all publish an article on these topics during the next year.* ■

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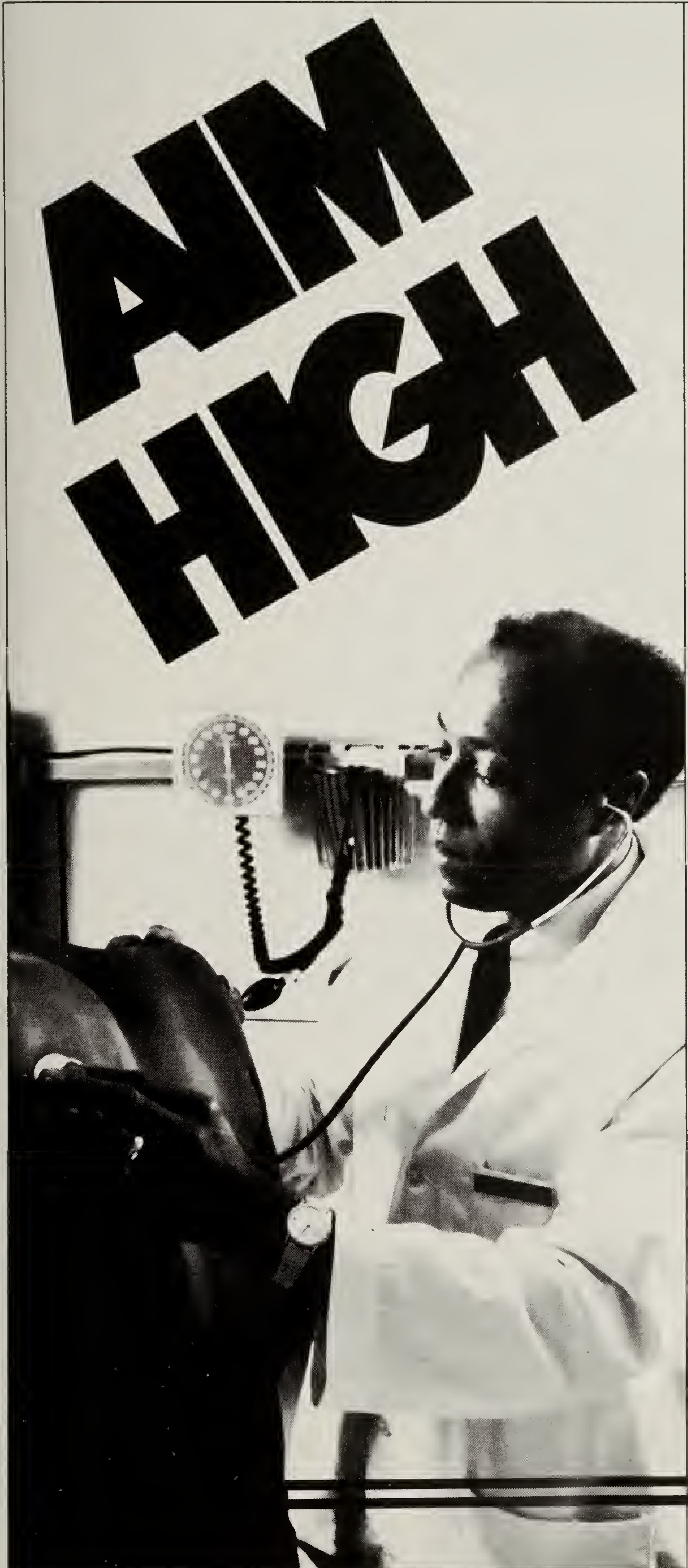

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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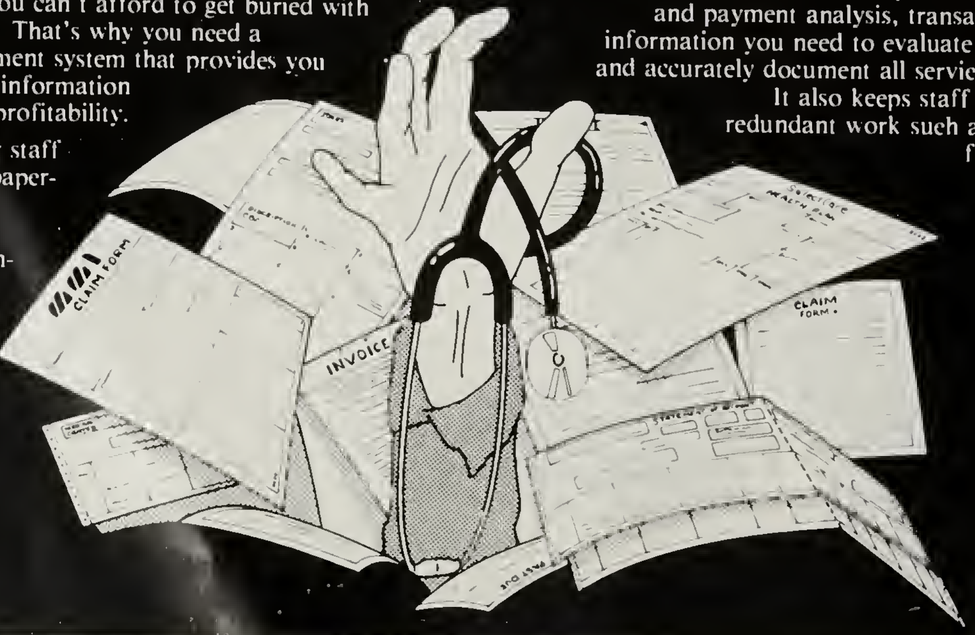

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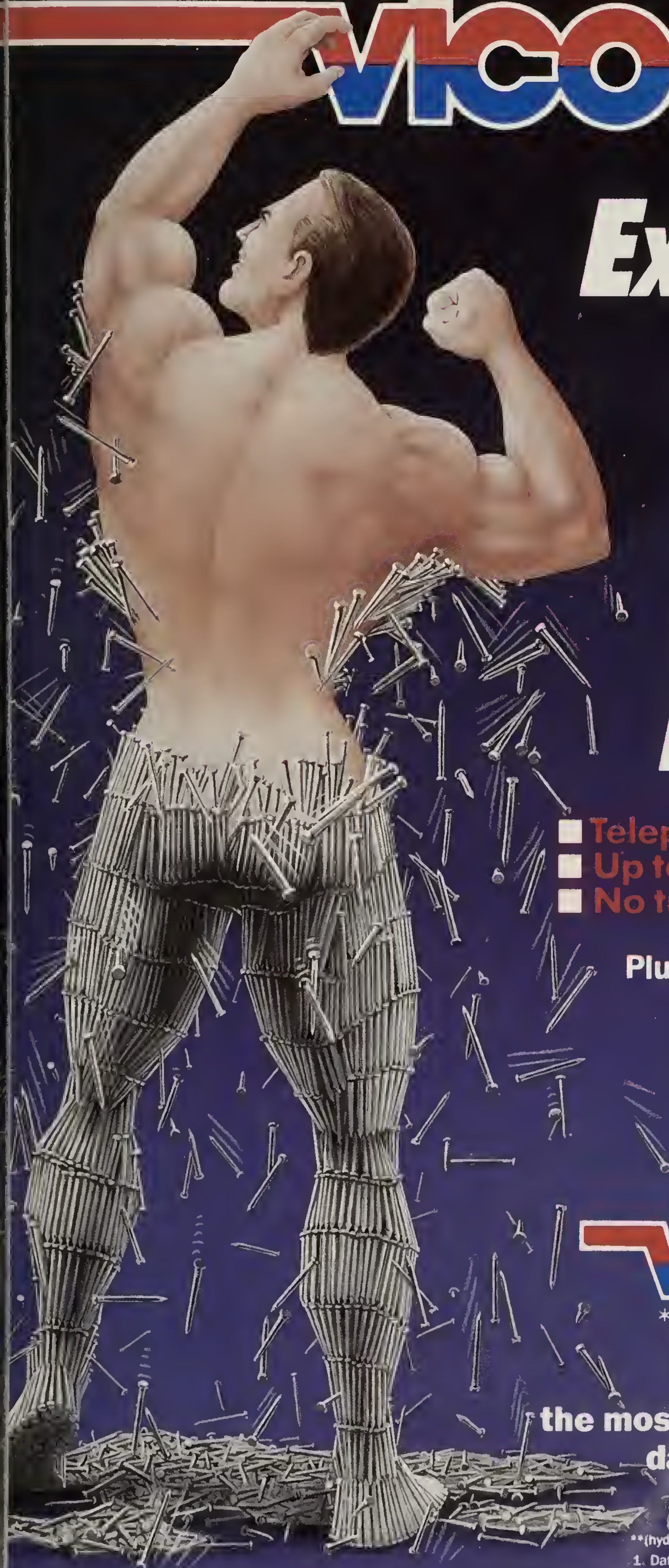

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Tablet for tablet, the most potent analgesic you can phone in daytime, nighttime, weekends.

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1. Data on file, Knoll Pharmaceuticals
2. Standard industry new prescription audit.

Please see adjacent page for brief summary of prescribing information.

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vicodin® CIII
(hydrocodone bitartrate 5mg [Warning: May be habit forming] and acetaminophen 500 mg)

vicodin ES® CIII
(hydrocodone bitartrate 7.5mg [Warning: May be habit forming] and acetaminophen 750 mg)

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy:
Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.
Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:
Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.
Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.
DRUG ABUSE AND DEPENDENCE:
VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.
OVERDOSAGE:
Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.
Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

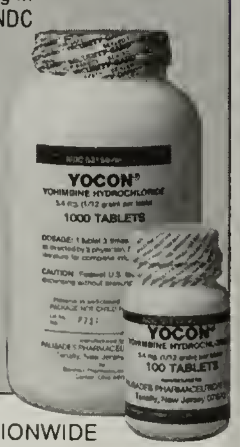
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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DEATHS

Mostafa I. Bonakdar, MD
West Bloomfield

Mostafa I. Bonakdar, MD, an obstetrician/gynecologist, died October 23. He was 50. Doctor Bonakdar graduated from the University of Isfahan, Iran, and the Iran Medical School. He completed his medical residency at Hutzel Hospital, Detroit. He started his practice in the Detroit area and shared offices in Detroit and Roseville. Doctor Bonakdar was affiliated with Hutzel Hospital and Macomb Hospital Center. He was an associate professor at Wayne State University, and was a member of MSMS.

John A. Hughes, MD
Novi

John A. Hughes, MD, a neurologist, died October 30. He was 61. Doctor Hughes attended the University of Michigan and received his medical degree from Wayne State University. He was on staff of Oakwood, St. Mary's, Harper and Samaritan hospitals, retiring from practice last year. He was a member of MSMS.

John E. Hauser, MD
Roanoke, Virginia

John E. Hauser, MD, a general surgeon, died November 10 at the age of 85. Doctor Hauser received his medical degree from Wayne State University College of Medicine. He practiced at Grace Hospital, Detroit, for 40 years. He was a Fellow of the American College of Surgeons and the International College of Surgeons. He served as a member and delegate to MSMS. He also was a member of the Wayne County Medical Society and the American Society of Abdominal Surgeons.

William B. Jensen, Jr., MD
Grand Rapids

William B. Jensen, Jr., MD, an anesthesiologist, died November 21. He was 65. Doctor Jensen was a 1948 graduate of the University of Michigan. His internship and residency were at Butterworth Hospital, Grand Rapids, from 1948 to 1952. In addition to his staff position at Butterworth, he served on the consulting staff of Kent Oaks Psychiatric and Forest View hospitals. Doctor Jensen was a member of the Kent County Medical Society and MSMS.

Arthur J. Stein, MD
Sarasota, Florida

Arthur J. Stein, MD, a radiologist, died October 31 at the age of 76. Doctor Jensen earned his medical degree from the University of Pennsylvania, Hahnaman Medical School. He served his residency at New York Bellevue Hospital. He was chief of staff, of the department of radiologist at the Hillsdale Community Health Center, Hillsdale, from 1948 until his retirement in 1986. Doctor Stein was a member of MSMS.

Martha R. Westerberg-Smith, MD
Ann Arbor

Martha R. Westerberg, MD, a neurologist, died November 7 at the age of 76. Doctor Westerberg received a bachelor's degree in 1934 from Rockford College. She received her medical degree from the University of Chicago. In 1941 she came to the University of Michigan to serve her internship and residency. Following her residency, she joined the staff of the University of Michigan Medical School, retiring in 1979 as professor of neurology. Upon her retirement, she was granted emeritus status by the Board of Regents. Doctor Westerberg was a member of the American Medical Association, the American Board of Psychiatry and Neurology, and MSMS.

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MEETINGS

MSMS Meetings

March

7, MSMS Young Physicians Section, Annual Meeting, Kellogg Center, East Lansing, MI. Contact: Debbie Zannoth, Chief, Membership Department (517) 337-1351.

13-14, MSMS Maternal and Perinatal Annual Conference, Ritz Carlton, Dearborn, MI. Contact: Sherry Fent, Chief, Physician Education (517) 337-1351.

16, MSMS Hospital Medical Staff Section Annual Assembly, Dearborn Inn, Dearborn, MI. Contact: F.B. "Tom" Plasman, Manager, Physician/Hospital Relations, (517) 337-1351.

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

23, MSMS International Medical Graduates Annual Meeting, Ritz Carlton, Dearborn, MI. Contact: Judy Marr, Manager, Communications (517) 337-1351.

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

AMA Meetings

February

13-15, National Communications Conference, Miami Beach, FL. Contact: American Medical Association, 515 North State St., Chicago, IL 60610.

15-17, National Leadership Conference, Fontainebleau Hilton, Phoenix, AZ. Contact: Stephanie Jaworskyj, Meeting Management (312) 464-5341.

Michigan Specialty Society Meetings

February

16, Film presentation: "Crimes and Misdemeanors", Farmington, MI. Contact: Colleen Jaeger (313) 559-5855.

28, "The Ego Resistances", Southfield, MI. Contact: Colleen Jaeger (313) 559-5855.

April

21-23, Uniting to Support Infants and Families in Crisis, University of Michigan Campus, Ann Arbor, MI. Contact: Kathleen Baltman (313) 577-5244.

National Specialty Society Meetings

February

18-20, Society of Thoracic Surgeons, San Francisco, CA. Contact: (312) 664-6610.

24-28, American Institute of Ultrasound in Medicine, Atlanta, GA. Contact: (301) 656-6117.

March

1-3, Neurology in Clinical Practice, Telemark Resort, Cable, WI. Contact: (507) 284-2509 or Toll Free (800) 323-2688.

1-6, American Academy of Allergy & Immunology, San Francisco, CA. Contact: (414) 272-6071.

3-7, American College of Cardiology, Atlanta, GA. Contact: (301) 897-5400.

7-12, American Academy of Orthopaedic Surgeons, Anaheim, CA. Contact: (708) 823-7186.

16-21, American Academy of Pediatrics – Spring Session, San Diego, CA. Contact: (708) 228-5005.

23-26, American Society on Aging, New Orleans, LA. Contact: (415) 543-2617.

April

11-13, American Society of Abdominal Surgeons, Tampa, FL. Contact: (301) 483-5471.

11-14, American College of Physicians, New Orleans, LA. Contact: (215) 351-2400.

21-23, National Council on Patient Information and Education, Washington, DC. Contact: (202) 347-6711.

21-25, American Association of Neurological Surgeons, New Orleans, LA. Contact: (708) 692-9500.

21-26, American Association of Immunologists, Atlanta, GA. Contact: (301) 530-7178.

21-27, American Academy of Neurology, Boston, MA. Contact: (612) 623-8115.

28-May/2, American Urological Association, Las Vegas, NV. Contact: (301) 727-1100.

29-May/3, American Pediatric Society, New Orleans, LA. Contact: (505) 764-9099.

May

3-6, Association of American Physicians, Seattle, WA. Contact: (609) 848-1000.

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gatroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-June/1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

Other Meetings

February

28-March/1, Children's Defense Fund Annual National Conference, Washington, DC. Contact: Donna M. Jablonski (202) 628-8787.

March

1-3, Mayo Foundation, Neurology in Clinical Practice, Cable, WI. Contact: (507) 284-2509 or toll-free (800) 323-2688.

10-15, 12th Annual Mammoth Mountain Emergency Medicine Ski Conference, Mammoth Lakes, CA. Contact: (714) 650-4156.

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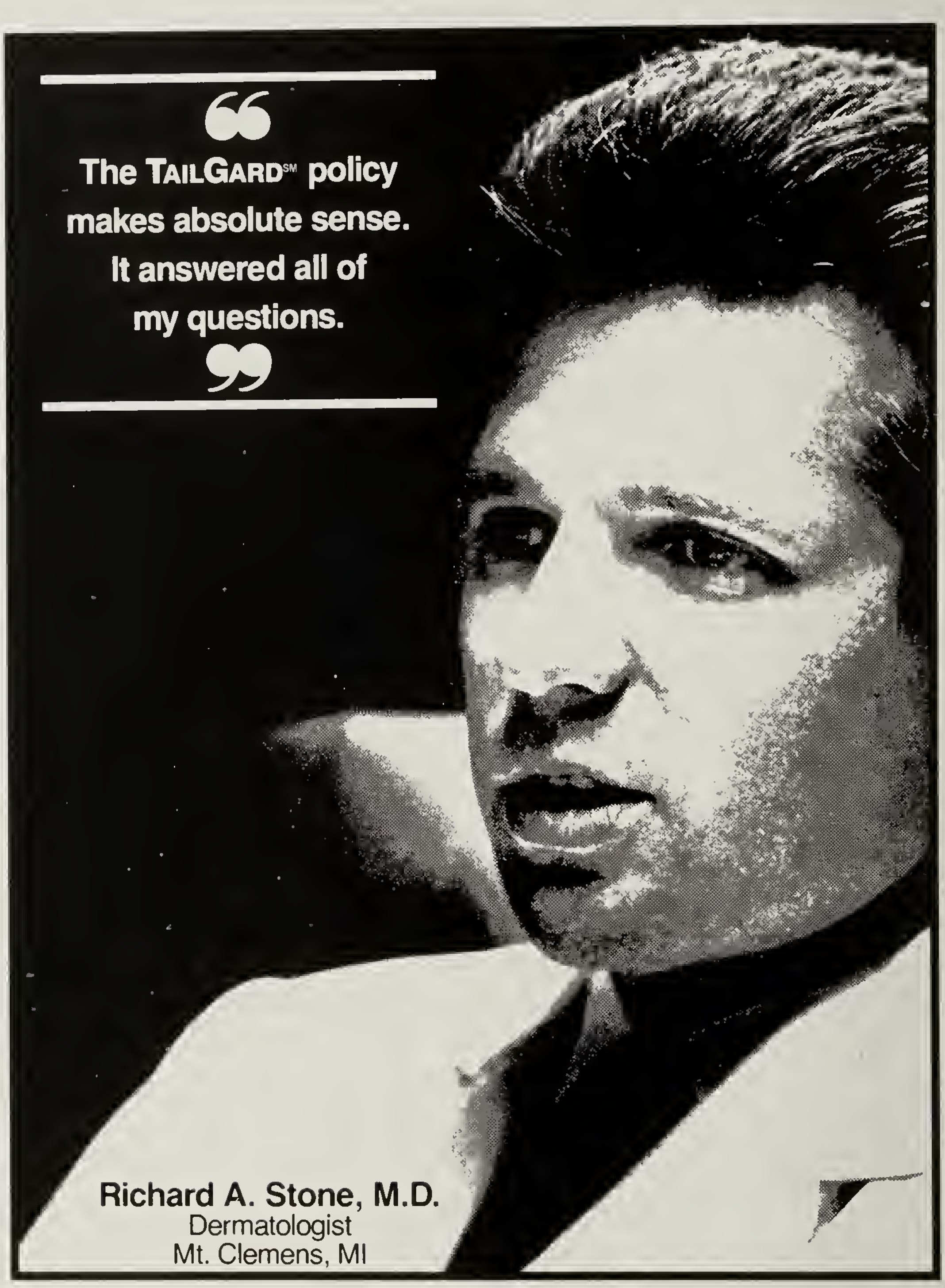

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

February

5,12,19, Crohn's Disease: A New Understanding. Location: Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 6 hours Category I Credit.

11-15, Ninth International Postgraduate Course On Myocardial Infarction and Angina Pectoris. Location: Convention Center, Davos, Switzerland. **Sponsors:** University of Michigan Medical School and Hannover Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 28 hours Category I Credit.

17-22, 16th Annual Seminar On Emergencies In Medicine. Location: Boyne Highlands Ski Lodge, Harbor Springs, Michigan. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

18-22, Cardiology. Location: Big Sky, Montana. **Sponsor:** Henry Ford Hospital. **Contact:** Shelly L. Helton Office of Continuing Medical Education, (313) 876-3073 or 1-800-888-4340. **Approved for:** 5.5 hours Category I Credit.

22-23, Endoscopic Sinus Surgery. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

22-24, 11th Annual Advances In The Management Of Infectious Diseases: Winter Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 13 hours Category I Credit.

March

3-6, A Symposium Featuring Fiberoptics - The Difficult Airway. Location: Red Lion's La Posada Resort, Scottsdale, Arizona. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

9, Perioperative Ischemia Update. Location: Henry Ford Hospital, Buerki Auditorium, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Shelley L. Helton, Office of Continuing Medical Education, (313) 876-3073 or 1-800-888-4340. **Approved for:** 5.75 hours Category I Credit.

10-15, Emergencies In Medicine. Location: Yarrow A. Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

12,19 Vague but Persistent Heart Complaints. Location: Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 6 hours Category I Credit.

16, Second Annual Symposium on Medical Complications of Pregnancy: Autoimmune Disorders in Pregnancy. Location: William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital. **Contact:** Liz Kretschmann, Office of Continuing Medical Education, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073-6769, (313) 551-0429. **Approved for:** 4 hours Category I Credit.

19-23, Fifteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School: Department of Family Practice and The Michigan Academy of Family Practice. **Contact:** Julie Jacobs, Registrar, Towlsey Center, (313) 936-9800. **Approved for:** 35 hours Category I Credit.

15-16, Recent Trends In Electrophysiologic Assessment Intraoperative Applications. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

19-23, Family Practice-1991: Fifteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 35 hours Category I Credit.

21-24, 11th Annual Advances In The Management of Infectious Diseases: Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

22, A Study In Hope: The Treatment and Management Of Alzheimer's Disease. Location: Fetzer Development Center, Western Michigan University, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies, Alzheimer's Disease and Related Disorders, Chapter of SW Michigan, and Kalamazoo Neurology. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 6.5 hours Category I Credit.

23-24, Regional Anesthesia: Anatomy & Techniques. Location: Wayne State University School of Medicine, Detroit, Michigan.

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Sponsor: Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 12 hours Category I Credit.

26-April/2, Chronic Fatigue Syndrome: Fad or Fact? Contact: David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 4 hours Category I Credit.

April

4-5, Challenges and Changes: Obstetrics and Gynecology In The 1990's. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University Of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-12, Ultrasound In Obstetrics And Gynecology. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 21 hours Category I Credit.

12-13, Innovations in G.I. Management. Location: Amway Grand Plaza, Grand Rapids, Michigan. **Sponsor:** Saint Mary's Health Services. **Contact:** Catrina Patterson, Marketing Department, (616) 774-6458. **Approved for:** 10 hours Category I Credit.

26-27, Evaluation and Management of Valvular Insufficiency. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Angela Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 764-2288. **Approved for:** 15 hours Category I Credit.

29-May/5, Advances In Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 33.5 hours Category I Credit.

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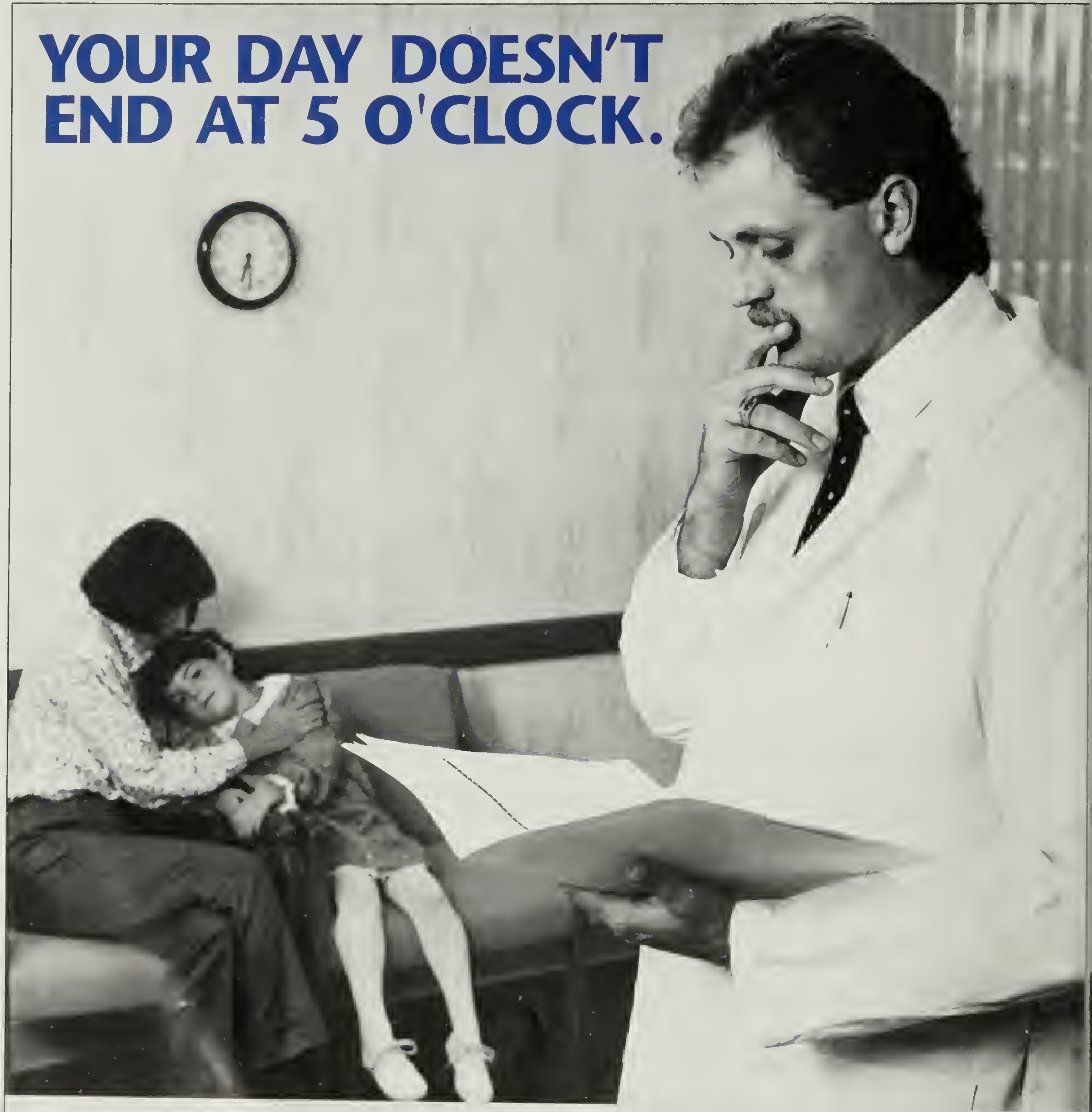

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PRESIDENT'S PAGE

Obtaining medical information — State legislation is needed

By Susan H. Adelman, MD

The telephone rang. The caller identified herself as a social worker assigned to Johnny Jones, a child I had seen that morning. Since she insisted on speaking with Doctor Adelman my secretary transferred the call to me.

The caller told me she was Mary Smith, the social worker for Johnny Jones. Then she asked, "Doctor Adelman, can you spell your name?"

Now what kind of a question is that? The answer is, "Of course I can." When I begged her pardon, she persisted, "How do you spell your name?" Now that I understood what she wanted, I spelled out my name.

"Johnny Jones was supposed to come to your office this morning. What happened?"

Her manner and tone of voice implied that something awful must have occurred. The answer that rose immediately to mind was, "Schevardnadze resigned, and the US government is very upset." Suspecting that she was after something different, I answered, "I saw Johnny Jones in the office today."

"Did you remove his thyroglossal duct cyst?"

"Did I do what? In the office?"

"Well, that is what he was sent to you for. Why didn't you remove it?"

"That is major surgery. I do not do major surgery in the office. I do it in the hospital."

"What did you do then?"

"I examined him. I took a history, did a physical, and evaluated him for surgery."

"Is that all? What is the family supposed to do now?"

"After the appointment, I suppose they went home. We will call them once we have contacted the hospital and obtained a date for me to perform the surgery, outpatient, in the operating room."

She then proceeded to work her way down a list of questions, querying me when the surgery would be done, where, why, how, and what medicine that child should take. I interrupted, telling her that she did not need to talk to me about any of this; she should talk to my secretary. Highly insulted, she asked why, and was satisfied neither with my answer that I was busy at the time nor with my assurance that my secretary was perfectly capable of answering all these questions by just reading the chart, without bothering me.

This was a close encounter of an exasperating kind, and it illustrates many problems with our current system of review by officious second-guessers, though in this case the worker was checking up primarily on the mother. First and foremost, she was rude. She did not apologize for interrupting me or for taking my time, and she did not properly introduce herself. Since she was obviously ignorant of accepted surgical procedures, she could have been a neighbor or a family member, for all I could tell. She provided no identification or authorization number, and she demonstrated no clear proof that she had the authority to give me a third degree in the middle of office hours.

She was untrained in the normal sequence of medical/surgical care. When I indicated that I had not performed surgery that morning in the office, she appeared shocked. She did not know how to properly ask a question, what questions a doctor needs to answer and what the nurse or office personnel can handle.

What are the solutions? We need state legislation to spell out who can obtain medical information, when it can be requested over the telephone and when in writing, what procedures should be followed to ensure some semblance of confidentiality, and how the requesting parties should be licensed or certified.

Anyone who calls for information should be able to furnish an authorization number, and the agency, managed care entity, third party administrator or insurer should be licensed, or at least registered, in the state. Unless the caller can provide this license or registration number upon request, no information should be given out about a patient to an unknown person on the telephone. Under the present unregulated system, many believe that now we should insist on a written request for information, accompanied by a release from the patient unless the health care contract waives the release, whenever a matter is not urgent. Once we get to know the personnel of a review agency, then this procedure could be supplanted by telephone contact if the time frame is short. We then can follow up in writing. Eventually, most of these exchanges will probably be done by electronic mail.

The state will have to start regulating utilization management and monitoring activities. It should require that persons who call for medical information be health care professionals, with proper training in telephone technique, and with standardized questions. It is time to insist on uniform utilization management guidelines, protocols and criteria throughout the state, to eliminate confusion, duplication, contradiction, and inefficiency. Health care professionals who perform medical reviews should be licensed to practice in the state. Any agencies which take it upon themselves to refuse authorization or precertification of services or procedures should have adequate professional liability insurance.

As far as the woman who called me is concerned, she should be barred from ever again harassing doctors over the telephone. I wonder if she can spell her own name. ■

Doctor Adelman is MSMS president.

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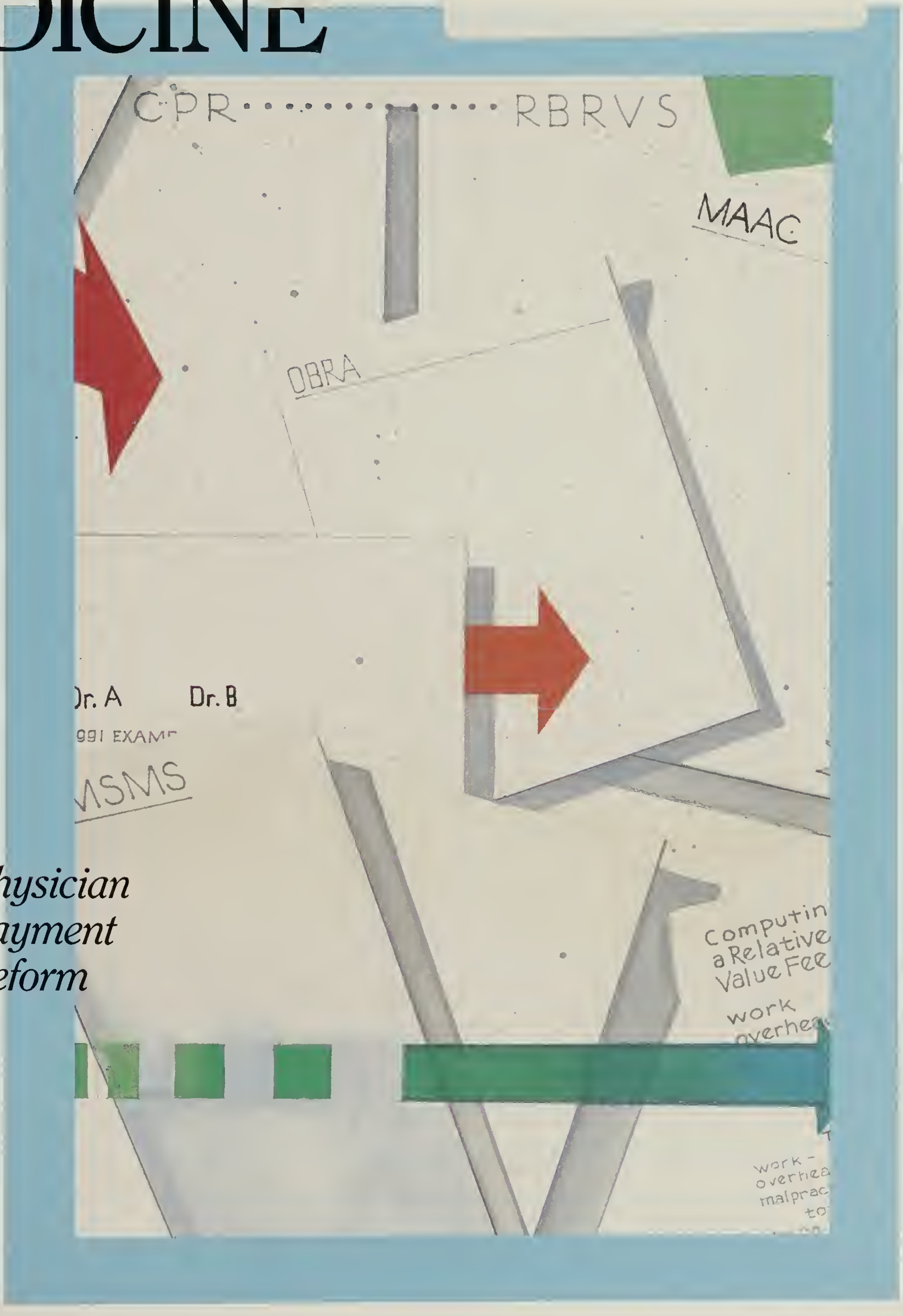
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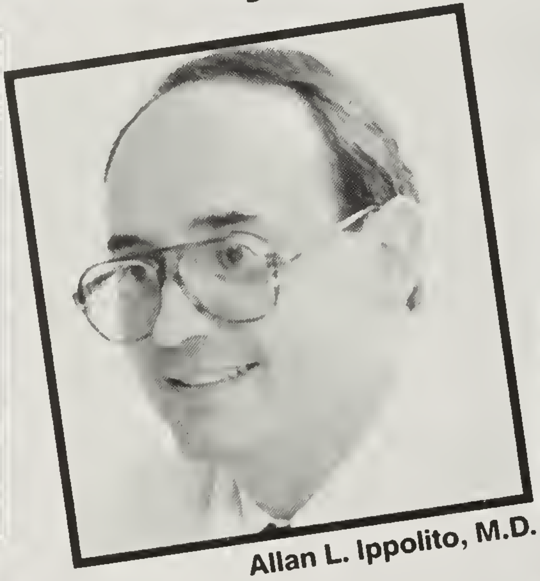

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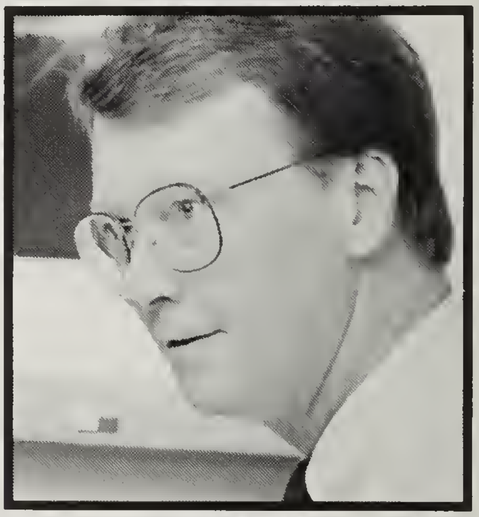

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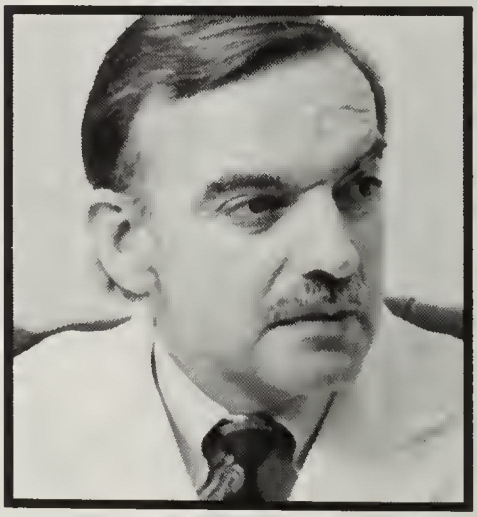

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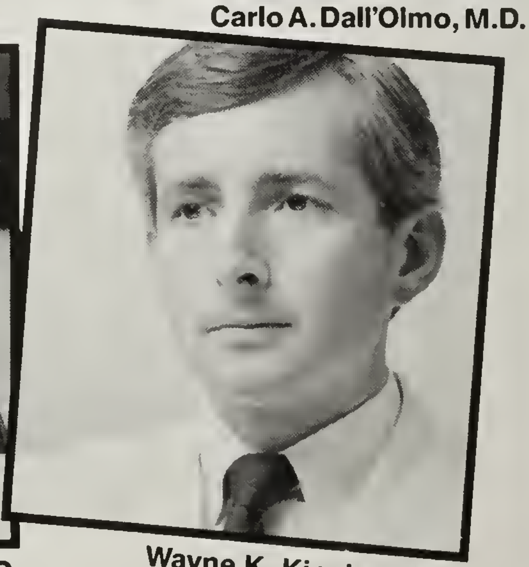

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MICHIGAN MEDICINE

14 COVER STORY

Physician payment reform in Michigan — it's coming and physicians should be prepared for it. This month's cover story examines the new Medicare physician payment system and how it will affect physicians nationwide. Also included is an examination of physician payment reform in the Omnibus Budget Reconciliation Act of 1990 and CPT coding revisions, which will be necessary for implementation of the Resource-Based Relative Value Scale. A list of all procedure codes that are considered for evaluation and management, examples for limiting charge calculations and the formula for calculating fees are also featured in this month's cover story. An introduction by Gilbert Bluhm, MD, chairman of the MSMS Advisory Committee to Section on Medical Economics, spells out the goals of physician payment reform and the fact that these goals "may be in danger if the federal government's budget proposals use the new system as a mechanism for reducing Medicare expenditures."

MAAC
Dr A
Dr B

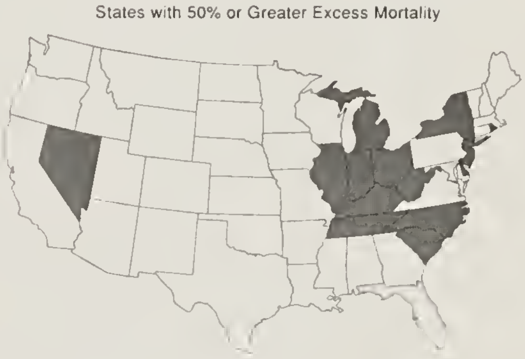
Page 14

FEATURES

23 THE BLUES' NEW PHYSICIAN PARTICIPATION AGREEMENT
Despite MSMS input on the contract's development, there are unresolved concerns about a number of areas.
— BY CLAUDIA SKUTAR

27 PROFESSIONAL LIABILITY REFORM
MSMS sees an opportunity for meaningful change, and makes professional liability reform its top legislative priority for 1991.
— BY THOMAS E. STONE, MD

31 MEDICAL INQUIRER
This is the third in a series of factsheets prepared by the MSMS Department of Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. Readers are encouraged to tear it out and save it for handy reference.



Page 31

35 CHANGING PATTERN OF RABIES IN MICHIGAN
A report from the Michigan Department of Public Health shows a changing pattern of rabies in Michigan.
— BY BYRON S. BERLIN, MD

DEPARTMENTS

5 In My Opinion
"The relationship of the medical staff with hospital administration and board of trustees not so harmonious"
BY PETER A. DUHAMEL, MD

7 Letters

9 Newsfronts

10 Physicians in the News

39 Deaths

40 New Members

43 Meetings

45 Category I Courses

50 Classifieds

55 Advertising Index

56 President's Page
"Physician-assisted suicide — A dilemma"
BY SUSAN H. ADELMAN, MD

Changing patterns of
RABIES
in Michigan

Page 35

n next month's issue of *Michigan Medicine:*
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IN MY OPINION

The relationship of the medical staff with hospital administration and board of trustees not so harmonious

By Peter A. Duhamel, MD

Almost all hospitals have a satisfactory relationship among their medical staff, administration and board of trustees. At least that's what the results of a 1987 JCAHO survey would lead us to believe. Perhaps we on the Governing Council of AMA/HMSS are the only ones who hear about the number of examples where these relationships are not all that great, and the occasional "horror stories." I expect we will continue to receive reports of more frequent confrontations, now that administrations are trying to challenge the autonomy of the hospital medical staff in "quality matters," which may also have a bottom line impact on hospital finances.

The most current example of this challenge is "economic credentialing," which was the subject of our recent HMSS educational program held during the 16th Assembly meeting in Orlando.

Traditionally, hospital medical staffs have had a "trust me" relationship with the administrations and trustees, even to the extent of using the hospital's freely-furnished legal counsel. So long as the economic interests of the hospital have been congruent with the medical staffs aims, there has been little conflict. But now that many hospitals are feeling the squeeze of diminishing payment from the Blues, Medicare, Medicaid, HMOs and the other third party payors, they are looking for other means of cutting costs. Many of them are attempting to improve their financial picture by either failing to reappoint, or down-grading the privileges of "non-productive" members of the medical staff. Frequently these actions are disguised in the veil of "quality control," and may be accepted as such by a gullible trusting medical staff.

The medical staff must make a stand on these issues, and not function as a rubber stamp for the administration in credentialing only those doctors who will turn a profit for the hospital, and demoting or deleting those who are economic "losers." This is of special importance now that all changes in medical staff status due to quality issues must be reported to the National Practitioner Data Bank.

Each medical staff must carefully examine its bylaws regarding credentialing, privileges, and medical staff status, to be certain that quality of care as assessed by the medical staff is the determining factor, and that the administration and board of trustees cannot make a unilateral decision based on economic issues.

Hopefully we have learned by now that whenever a hustle approaches us with a "trust me," we should reply "put it in writing!."..What do the bylaws say? ■

Doctor Duhamel is vice-chairman, AMA Hospital Medical Staff Section and former chairman, MSMS Hospital Medical Staff Section.

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Letters from Our Readers

Medical waste is only a small part of a major waste problem

A full page letter in the December 1990 issue of Michigan Medicine from the American Medical Association Department of Consulting Services says that physicians should get involved in the safe disposal of radioactive waste. It says 25-30 percent of "low-level" radioactive waste in the US comes from medical use. However, that 25-30 percent is volume which is not the major problem. Radioactivity is the problem.

Rogers Engineering Corporation of St. Paul, Minnesota, was hired by the Midwest Compact Commission to determine the radioactive characteristics of this waste. They found that the Compact will dispose of 247,000 curies of "low-level" waste over the 20 year operating life of the first facility, which is planned for Michigan. Utilities will account for 207,000 curies, or 84 percent, compared with only 130 curies, or 0.05 percent, from medical procedures. The rest will come from academic, government and industrial sources.

The unsolved high-level waste problem is almost exclusively from nuclear power and weapons production.

Most radionuclides used in medicine have short half lives (Tc 99m, 6 hours; 1 131, 8 days; Ga67, 3 days, etc.). They can be disposed of with routine rubbish after an appropriate hold up time. A few, with long half lives, are sent back to the manufacturer.

The letter suggests that one or two intermediate storage sites might be used until a permanent site is available. Some reactor sites might be suitable. The medical, government, academic and industrial waste could be stored with reactor waste on the reactor sites in appropriate structures. Then 50 years after the reactors close down, when they have partially cooled off radiologically, all the waste could be sorted, compacted, and shipped to a site on the millions of acres of arid, federal lands for permanent disposal. This would require changes in state and federal laws.

The flawed Catastrophic Health Insurance Act was sent back to Congress and cancelled in less than a year after it was passed. The same thing must be done with the Low Level Waste Policy Act of 1980 and 1985. If the present Act is carried out, after 150 years, every state in the union will have a low level dump, increasing the risk of accidents, leaks and spills at inappropriate sites. These things happen now.

The projected quantity of these wastes require only two or three dumps for the entire country. They must be protected from water. Michigan hardly seems a suitable site. It is practically surrounded by the largest body of fresh water on Earth.

The article says "physicians can play a key role in helping their states develop acceptable facilities...with an informed perspective on risk...and benefits from procedures that produce radioactive waste..." This is true. Physicians should protect people from any unnecessary radiation exposure from any source. No responsible physician exposes his patients to radiation from diagnostic or therapeutic procedures if he can provide the correct diagnosis and therapy without it. This same principle should be applied to producing electricity. If we can produce it without exposing the population to even very minute doses of radiation that should be done. Recent studies show low doses of radiation are three to four times more carcinogenic than previously estimated. Yet, the Nuclear Regulatory Commission plans to increase some maximum allowable doses and discard, in community dumps, about a third of "low-level" waste as "below regulatory concern."

The Federal government is responsible for this waste problem to a significant degree because it has promoted and heavily subsidized nuclear energy beginning with the Atomic Energy Act of 1954. Forcing the states to take title to and liability for these wastes is unconstitutional and an infringement on the sovereignty of the State of Michigan, according to a suit brought by the State of Michigan.

In Sweden the producers of radioactive wastes keep ownership of and liability for them. They are responsible for their disposal subject to government regulations and surveillance. The United States should do the same.

Physicians should not allow a relatively minor medical waste problem to be used to bail out a major waste problem from nuclear power. They should work to send the Low Level Waste Act back to Congress for cancellation and rewriting.

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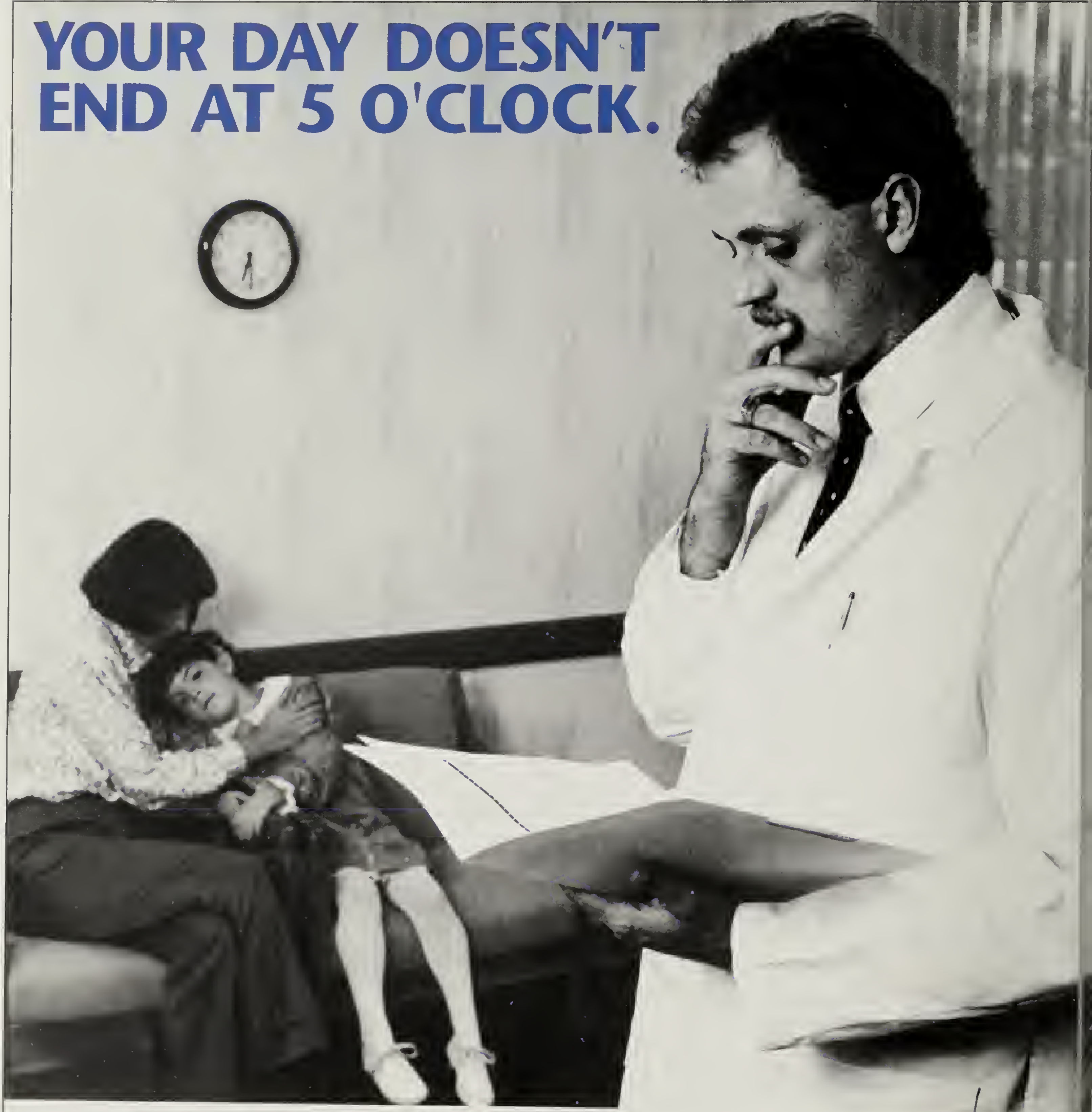

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MEDICAL NEWSFRONTS

INDEX

WSU part of national study to test AIDS therapies 9

Henry Ford to arrange national study aimed at reducing ravages of stroke 9

Beaumont seeks volunteers for weight loss, diabetes studies 9

Doctors/nurses continue to take risks when handling needles, U-M reports 10

Survey rates WSU med school high in atmosphere, publications 11

MDPH surveys maternal HIV infection rates in Michigan 11

Sinai utilizes cordocentesis for in utero blood transfusion 11

MHCERF awards grants to study nursing home care, geriatric care, and mammography screenings 12

MDPH streamlines CON paperwork 12

WSU part of national study to test AIDS therapies

The Comprehensive AIDS Alliance of Detroit, a coalition of community hospital physicians based at Wayne State University, will take part in the first national clinical trial to compare the effectiveness and safety of two experimental AIDS therapies, ddI (dideoxyinosine) and ddC (dideoxyxytidine). Initiated by the National Institute of Allergy and Infectious Diseases (NIAID), the trial will be led locally by principal investigator Lawrence Crane, MD, associate professor of medicine, WSU and section chief of infectious diseases, Harper-Grace Hospital.

The two-year study will be conducted at 18 sites in 14 cities nationwide as part of NIAIDS's Community Programs for Clinical Research on AIDS (CPCRA). Four hundred persons infected with the human immunodeficiency virus (HIV) are expected to enroll. Participants must be either intolerant of or have failed treatment with the antiviral agent AZT.

AZT remains the only antiviral drug that is approved as an AIDS therapy. Both AZT and ddI, one of the drugs to be studied, were discovered by WSU professor of medicine, Jerome P. Horwitz, PhD, a faculty member since 1956. AZT was licensed by the Food and Drug Administration in 1987 and has slowed HIV disease and prolonged the lives of thousands of HIV-infected persons. However, some side effects and possible resistance to the drug after one to three years of use have prompted studies of alternative AIDS treatments.

"This study is very important as it will not only add to our knowledge of AIDS treatment, but also benefit those persons who are participating in the research. For the first time, we will be able to bring new treatments to persons with HIV/AIDS who live here in Detroit," Doctor Crane said.

Both ddI and ddC showed promising activity against the AIDS virus in Phase I studies. Patients in these studies showed an increased number of T4 cells, weight gain and higher energy levels. However, some side effects were reported at high doses of ddI and ddC. The purpose of this new protocol is to compare, in patients who take ddI and ddC, the rates of occurrence of disease progression, the frequency and severity of side effects, and the effects of T4 cell counts.

Physicians, patients and others interested in the clinical trials can contact Doctor Crane at (313) 993-0934 or 1-800-TRIALS-A, a toll-free service sponsored by the Public Health Service from 9 a.m. to 7 p.m., Monday through Friday.

Henry Ford to arrange national study aimed at reducing ravages of stroke

Henry Ford Hospital was recently named the coordinating center for a nationwide study of a clot-busting drug which researchers hope will provide the first treatment ever for altering the course of a stroke.

Henry Ford Hospital's Center for Stroke Researcyh within the Department of Neurology was also selected as one of nine clinical centers in the study.

Funded by the National Institutes of Health, the study will determine if the clot-dissolving drug TPA can be used to stop strokes early into the symptoms. TPA, or tissue plasminogen activator, is already being used successfully to halt heart attacks.

Approximately seven out of eight stokes occur when a blood clot becomes lodged in an artery and suddenly blocks the flow of blood in the brain. By using TPA to break up those clots, doctors hope to be able to restore blood flow in time to minimize brain damage. There is a catch. To rescue the brain from stroke damage, TPA has to be administered very soon after a blockage occurs. In the study, patients will be divided into two groups: those who received treatment within 90 minutes and those who are treated between 90 minutes and three hours.

Because the public and even some doctors are accustomed to viewing stroke as untreatable, convincing stroke victims to seek treatment as soon as they notice their symptomsss could become one of the researchers' major challenges. Currently, only about five percent of stroke victims go to an emergency room within 19 minutes of experiencing a stroke.

"Symptoms of stroke should be considered a medical emergency, just like a heart attack," according to Steven R. Levine, MD, of the Center for Stroke Research and Department of Neurology, who will serve as the principal investigator of the study's clinical component. "Maybe if we changed the term 'stroke' to 'brain attack' people would better understand the need for urgency."

Henry Ford Hospital was appointed the coordinating center on the basis of its scientific merit. This represents the first time the institution has been selected as the coordinating center on a nationally-funded research grant.

Beaumont seeks volunteers for weight loss, diabetes studies

The weight study program at the Beaumont Clinics of Preventive and Nutritional Medicine is seeking overweight individuals to participate in a weight loss study.

Volunteers must be between the ages of 18 and 65 years, with a round-shaped body.

Continued on page 10

Continued from previous page

Participating women must be of a non-childbearing potential.

The four-month study is to evaluate the effectiveness of a new investigational drug used in combination with extensive dietary counseling.

For more information on the study, or to volunteer, call (313) 645-8158.

The Beaumont Clinic is also seeking volunteers for three diabetic studies.

The first study involves a medication that may prevent the progression of diabetic eye disease. The medication under study blocks an enzyme present in eye cells that converts blood sugar to sorbitol, untimately damaging the eye. Candidates for this study must be between 18 and 72 years of age and have Type I or Type II diabetes. Persons with glaucoma, cataracts or a history of eye surgery or laser eye therapy are excluded from the study.

Another study compares the effectiveness and safety of an oral medication to control diabetes and insulin therapy in persons with adult onset diabetes. The study will also measure the quality of life of participants. Volunteers must be between 35 and 70 years and currently receiving insulin therapy. Participants will switch from insulin to glipizide during the course of the five-month study.

A third study researches kidney disease as a complication of diabetes related to high levels of sugar in blood and body tissues. Participants in this study will receive a medication that reduced the level of sugar in body tissues, an actino that may prevent the progression of diabetic kidney disease. Volunteers must be 18-54 years of age ahd have insulin dependent diabetes.

Persons interested in volunteering for these studies should call the Beaumont Clinics at (313) 646-6500.

Doctors/nurses continue to take risks when handling needles, U-M reports

A University of Michigan survey of four major teaching hospitals found that many physicians and nurses continue to recap needles even though the Centers for Disease Control (CDC) established a nationwide policy in 1987 forbidding it.

The policy, which directed health care workers to drop used needles in special disposal boxes instead of recaping them, was established to protect hospital and clinical workers from contracting AIDS and hepatitis B through accidental needle sticks.

"Inadequate knowledge and old habits seem to be more powerful determinants of behavior than hospital staff education programs and written policies," say Marshall H. Becker, professor of helath behavior and health education at the U-M School of Public Health, and Nancy K. Janz, assistant research scientist at the School.

Nearly a third of the health care workers in the U-M survey did not disagree with the statement that "recapping needles provides protection for me" against contracting hepatitis B and AIDS, and nearly 50 percent felt recapping protected their colleagues.

"Most disturbingly, 30 percent actually agreed at least somewhat with the statement, 'I would recap a needle if I knew the patient had AIDS,'" the U-M researchers say.

The survey, which included 110 physicians and 91 nurses at the four largest hospitals in southeast Michigan, collected data on capping habits, knowledge of and attitudes toward the CDC protocol, estimated exposure to infected

Continued on page 11

Physicians in the News

Thomas C. Payne, MD, a Lansing radiologist, is the recipient of the Second Annual Presidential Citation Award of the Ingham County Medical Society. The award recognizes the significant contribution of a physician member to both the practice of medicine and the community.

James R. Irwin, MD, an obstetrician/gynecologist, is the new president of the Kent County Medical Society. Doctor Irwin received his pre-medical and medical degrees from Wayne State University and took his internship and residency in obstetrics and gynecology at Butterworth Hospital, Grand Rapids. He has been in practice in Grand Rapids since 1965.

Other newly-elected officers of the Kent County Medical Society include : **Charles R. Henry, MD,** president-elect; and **Douglas A. Edema, MD,** secretary-treasurer.

Sol Pickard, MD, Huntington Woods, is the recipient of the Dodrill Award for Excellence from the American Heart Association of Michigan. Doctor Pickard, who is senior staff cardiologist and director of the Pacemaker Laboratory, Henry Ford Hospital, Detroit, was selected for his contributions to heart research and education.

Kevin M. Fickenscher, MD, assistant dean and president/CEO, Michigan State University Kalamazoo Center for Medical Studies, is newly-named *1991 Emerging Leader in Health Care.* The award, given by Healthcare Forum, a national health industry group based in San Francisco, and Korn/Ferry, the largest health care personnel recruiting firm in the nation, is presented to only six people in the country each year. The award will be formally presented to Doctor Fickenscher at the Annual Conference of the Healthcare Forum in April.

Thomas L. Haynes, MD, is the newly-appointed medical director of River Valley Recovery Center, Grand Rapids. Doctor Haynes, who is certified in addiction medicine by the American Society of Addiction Medicine, specializes in the treatment of the chemically-dependent health profesisonal. He is a member of the MSMS Steering Committee to Assist the Impaired Physician and the MSMS Focus Group on Chemical Dependency.

Paul O. Farr, MD, is the newly-elected president of the Kent County Medical Foundation. The Foundation, a charitable trust founded by the Kent County Medical Society in 1961 and incorporated in 1966, gives financial assistance to students from Kent and bordering counties who are pursuing careers in medicine and allied health fields.

Continued from previous page

patients, and sense of personal risk. The researchers also conducted unannounced counts of capped and uncapped needles in disposal boxes in surgical and medical intensive care units, emergency rooms, and surgical wards.

"We found that more than 25 percent of the needles in our counts were recapped, and on four occasions, more than half of them were capped," say Becker and Janz.

Despite the tendency to recap, most of the physicians and nurses know their professions put them at risk, the researchers say. Sixty-six percent of the workers agreed with the statement, 'I worry that my work activities put me at risk of contracting AIDS,' and 77 percent acknowledged that they have 'extensive contact' with patients who have hepatitis B or AIDS."

Why, then, do some continue to recap? "Almost two-thirds think it is highly unlikely that they will get AIDS from an accidental needle stick. They just don't seem to perceive recapping as risky behavior," say Becker and Janz. "Indeed, many misconstrue the CDC policy and believe the Center recommends recapping."

Another reason, the researchers say, is simply that "it is harder to unlearn old habits like recapping, which was almost universally practiced before 1987, than it is to learn new ones."

To change staff habits, Becker and Janz recommend that hospitals focus on changing the capping habits of head nurses and physicians who direct departments, because they are role models for other employees.

"We also know that physicians and nurses are curious about how their behavior compares with their peers, so we suggest hospitals do surveys and let staff know how they measure up. And, since many workers say they recap simply because they forget not to, put prominent signs on the walls and reminders on patient charts," they add.

Survey rates WSU med school high in atmosphere, publications

The Wayne State University School of Medicine received high ratings in a recent survey of medical schools in the continental United States.

According to the survey, Wayne State ranks in the top sixth of the nation's 126 medical schools for both quality of academic atmosphere and for the most frequently cited publications. The results were published in *Academic Environment: A Handbook for Evaluating Faculty Employment Opportunities*, by Karl W. Lanks, MD, professor of pathology and director of the graduate program at the State University of New York Health Science Center at Brooklyn. The book was published in 1990 as a guide to help graduating medical students evaluate the atmosphere and working conditions at prospective hiring universities.

MDPH surveys maternal HIV infection rates in Michigan

The Disease Surveillance Section, Bureau of Laboratory and Epidemiological Services, Michigan Department of Public Health, began a statewide, unlinked seroprevalence survey of Human Immunodeficiency Virus (HIV) infection among childbearing women in the summer of 1989. The survey utilizes discarded heel stick, filter paper specimens from the neonatal metabolic screening program. Specimens for screening for metabolic disease are required to be submitted on all live born Michigan newborns. All individual identifying information is removed from the specimens prior to testing so that none of the testing information can be linked to an individual newborn or mother.

A total of 294,159 specimens were tested for presence of maternal antibody between July 1988 and June 1990. Two hundred specimens or 6.8 per 10,000 overall have tested positive for HIV antibody.

One-hundred-fifty-five of the positives occurred among the 133,866 newborns whose mother was known to reside in the Detroit Metropolitan Statistical Area (MSA). The overall rate of maternal antibody positivity for the Detroit MSA was 12 per 10,000. Thirty-seven of the positives occurred among the 145,560 newborns whose mother was known to reside in the five regions of the state outside of the Detroit MSA. The overall rate of maternal antibody positivity outside of the Detroit MSA was 2.5 per 10,000. Between one and 12 seropositive specimens were identified in each outstate region over the two-year period. Eight positives occurred among newborns whose mother's residence was out of state or unknown.

Data on race and age group of the mother has been included in the database since April 1989. Over the 15-month period between April 1989 and June 1990, 84 of the 35,454 specimens from black individuals tested positive. Twenty-two of the 127,206 specimens from white individuals tested positive. The rate of positivity in blacks, 24 per 10,000, is nearly 14 times the rate in whites, 1.7 per 10,000. The relative difference in rates between black and white women holds both within the Detroit MSA and for the Outstate Area. Four of 3,022 specimens from hispanic individuals, or 13 per 10,000, tested positive.

The rate of HIV antibody positivity increases with maternal age from nine positives of 21,442 specimens tested, or 4.2 per 10,000, in the less than 20-year-old age group to 36 positives of 44,656 specimens tested, or 8.1 per 10,000, in the over 30-year-old age group.

The seroprevalence rates have remained relatively stable within all regions, by race for blacks and whites and within age groups over time. The potential for disproportionate increases in HIV infection in women related to heterosexual transmission and IV drug use is real, however, the relatively stable rates observed in this survey imply that no marked changes have occurred in Michigan over the past two years. Prevalance rates among black mothers and mothers residing in the Detroit MSA remain well above those of white mothers and mothers residing outside the Detroit MSA. The data indicate that urban populations and people of color are at increased risk of exposure to HIV infection in Michigan.

Sinai utilizes cordocentesis for in utero blood transfusion

Sinai Hospital's Department of Obstetrics and Gynecology recently conducted the hospital's first in utero blood transfusion using the technique of cordocentesis on a fetus.

"The process of in utero transfusion has been greatly improved over the past five years and is more effective," says David Schwartz, MD, chairman of Obstetrics and Gynecology at Sinai. "Sinai is one of a limited number of hospitals in metro Detroit who have the technology and the skill to conduct this procedure."

An in utero blood transfusion is conducted in cases of Rh incompatibility which poses a risk to the mother and the fetus.

"In such cases the mother's blood and the baby's blood do not match," said Gregory

Continued on page 12

Continued from page 11

Goyert, MD, a specialist in maternal-fetal medicine at Sinai. "The mother then produces antibodies which destroy the baby's red blood cells leaving the baby's hemoglobin low. In such cases, the baby may be at risk of dying."

Through the process of cordocentesis, a blood sample is taken directly from the umbilical cord, and the baby's hemogiogin is checked to determine if a transfusion is necessary.

Using ultrasound guidance, blood is then transfused directly into the baby's bloodstream via the umbilical cord. The process is repeated every one or two weeks and the baby is then delivered when it is sufficiently mature.

MHCERF awards grants to study nursing home care, geriatric care, and mammography screenings

A University of Michigan researcher will prepare a comprehensive forecast on the demand for nursing home and hospital care by the state's elderly with a $56,310 grant from the Michigan Health Care Education and Research Foundation (MHCERF), the research and philanthropic affiliate of Blue Cross and Blue Shield of Michigan.

In addition, a study to develop an educational program to help physicians deliver lower cost medical care to the elderly without compromising quality of care, will be funded by a $50,000 grant from MHCERF.

Finally, a $55,206 MHCERF grant will fund the final phase of a study on how to encourage older women to follow through on mammography screenings for early detection of breast cancer.

The study to assess demand for nursing home care, when completed, will be the most far-reaching of its kind in Michigan. Jersey Liang, PhD, a researcher at the University of Michigan, will also study the cost and policy implications that may arise from the demand for long-term care.

The study on low cost medical care for the elderly will be conducted by John E. Billi, MD, of the Department of Internal Medicine, University of Michigan Medical School. The educational program will be used for one year by a group of physicians at the U-M Hospital who will receive monthly orientations on common geriatric procedures and cost saving strategies.

Neal W. Persky, MD, of the U-M Institute of Gerontology, and Robert C. Burack, MD, of the Department of Internal Medicine, Wayne State University, will conuct the study of mammography screenings.

MDPH streamlines CON paperwork

In a major regulatory reform in the Certificate of Need (CON) program, the Michigan Department of Public Health (MDPH) is reducing paperwork requirements and review periods for four types of health care projects:

- changes in ownership
- changes in the site of licensed beds
- addition of sites to mobile equipment routes
- replacement of medical and non-medical equipment

"This action reflects Governor Engler's commitment to reduce needless paperwork and to improve the efficiency of state agencies," said Department of Public Health Director Vernice Davis Anthony.

The new procedures are now being finalized. They will be made retroactive and apply to both pending and future applications. For more information, call Walter S. Wheeler, chief, Bureau of Health Facilities, at (517) 335-8558. ■

Michigan State Medical Society

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PHONE(S) ____________________ BEST TIME TO CALL ____________________
PLAN TO PURCHASE/LEASE SYSTEM: 3 MONTHS [ ] 6 MONTHS [ ]
9 MONTHS [ ] 12 MONTHS [ ]
REMARKS: ____
____

Payment = [(RVUw x GPCIw) + (RVUoh x GPC
CPR
RBRVS
OBRA
Dr. A
Dr. B
1991 EXAM
MSMS

Cover Story

WILL PHYSICIAN PAYMENT REFORM ACHIEVE ITS GOALS?

By Gilbert B. Bluhm, MD

m)] × CF
CTP
HCFA
HHS
"LIMITING CHARGE"
MEI
MVPS
PPRC
AMA
PH
GPCI
rmediate
20.6
10.7
1.1
32.7
5 × 1.059 = 5.45
= 15.45
= 1.91

The Omnibus Budget Reconciliation Act (OBRA) of 1989 contained the most sweeping changes to physician reimbursement since inception of the Medicare program. The comprehensive package of physician payment reforms contained three major elements:

1) A fee schedule for physician services based on a resource based relative value scale (RBRVS) replaces the current "reasonable" charge mechanism;

2) Medicare volume performance standards (MVPS) to slow the annual rate of increase in expenditures for physician services; and

Continued on next page

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3) Limiting charges to replace the Maximum Allowable Actual Charge (MAAC). The 1991 limiting charge for nonparticipating physicians can be no more than 125 percent of the 1991 nonparticipating prevailing charge amount, except for evaluation and management services that are capped at 140 percent.

In addition to these reforms, OBRA 90 included many revisions to the Medicare Part B program and these are explained in further detail.

Since the enactment of OBRA 90 additional changes to refine the new system of physician payment have been proposed. A more uniform coding system for office visits is currently under development by the AMA and Physician Payment Review Commission (PPRC), which may include a time element. Details of the new coding system are discussed in an accompanying article. Many surgery codes will also be revised to standardize definition (and thus clarify) and reimbursement.

However, some of the most major changes under the RBRVS will be achieved by cuts made to the federal budget. As much as $9 billion will be cut from the Medicare program for physician services over the next five years. Because 1991 will serve as the base year for determining what the new RBRVS fees will be, the cuts made to this year's budget will continue to be felt over the next four years as the RBRVS is phased in.

The AMA has been an advocate for an equitable system of physician payment for the last several years to replace "customary, prevailing and reasonable" (CPR) payment limits.

Where CPR has been criticized as inflationary and distorted, the Resource Based Relative Value Scale, as envisioned by the PPRC, would make Medicare expenditures predictable and eliminate distortions in relative payments that are inequitable for patients and to physicians. It would improve the physician-patient relationship by providing fair Medicare payment levels and thus, improved access to medical care. It would simplify Medicare administration and reduce costs because carriers would no longer need to maintain individual physician fee profiles.

These goals, however, may be in danger if the federal government's budget proposals use the new system as a mechanism for reducing Medicare expenditures. ■

Doctor Bluhm is Chairman of the MSMS Advisory Committee to Section on Medical Economics.

RBRVS
MAAC
"LIMITING CHARGE"

THE **NEW** MEDICARE PHYSICIAN PAYMENT SYSTEM

A look at what's in store for physicians nationwide

By Rose B. Heald

Background

On November 22, 1989, Congress adopted legislation as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) that will implement a new physician payment system for Medicare beginning January 1, 1992. The recent history of this major legislation can be traced to September 1988, when the final report of Phase I of Harvard University's congressionally-mandated resourced-based relative value scale (RBRVS) study was issued.

The RBRVS rates the different services that physicians provide according to the costs of the resources needed to provide them, including physician work, practice costs, and specialty training. In Phase I of the Harvard study, which began in 1985 under the direction of Harvard professor William Hsiao, an RBRVS was developed for 18 medical and surgical specialties. Phase II, which was recently completed, includes expansion of the RBRVS to 14 additional specialties and subspecialties, methodological refinements, and restudy of four Phase I specialties.

After review of the Phase I Harvard study, the AMA House of Delegates at its Interim Session in December 1988 reaffirmed its support for replacing CPR with an RBRVS-based payment schedule. The AMA adopted the policy that the RBRVS study, when expanded and refined, would provide an acceptable basis for such a payment schedule. In the spring of 1989, the Physician Payment Review Commission (PPRC) joined the AMA in supporting a Medicare payment schedule based on a refined RBRVS.

The profession's support for the RBRVS, the PPRC's recommendations, and the availability of the initial study findings prompted three congressional committees to develop physician payment reform proposals during 1989. Differences between the proposals were reconciled during the fiscal year 1990 Federal Budget Process. The resulting physician payment provisions will begin a five-year transition to the new payment schedule in 1992.

System of payment

The cornerstone of the new payment system is composed of three components:

- the relative physician work involved in the provision of a service defined as time, mental effort, technical skill & stress;
- overhead costs, such as rent, staff salaries, equipment and supplies; and
- professional liability insurance (PLI) costs.

The work component of the payment schedule is based on the RBRVS. Initially, the overhead and PLI components was based on a portion of current Medicare charges for a service. Separate geographic practice cost indices (GPCI) have been developed for the three components of the fee schedule.

The Relative Value Unit (RVU) will be multiplied by a monetary conversion factor. The RVUs for work, office overhead and PLI costs will be adjusted for geographic differences. (See chart on page 18 for formula.) Research by Harvard University continues although their Phase II report was filed in December 1990. The AMA will be working closely with the Harvard study team and the Physician Payment Review Commission (PPRC) to complete and refine the RBRVS.

The conversion factor for 1992 will be "budget neutral," meaning that it will be calculated to result in the same amount of dollars being expended under the new system as would have been spent under a continuation of CPR. Thereafter, the intent is for the conversion factor to be updated by Congress based on the percentage increase in the Medicare Economic Index.

Transition to system

OBRA 89 established a five-year transition to the new system, although much of the change will occur in 1992, the first year of the transition period. There are three basic steps to the transition:

Step 1: Elimination of Specialty Differentials. Prior to establishing the 1992 payment levels, prevailing charges in each locality will be "adjusted" in a manner than eliminates specialty differentials, as well as customary charge profiles. The adjusted prevailing charge for a service will essentially be the weighted average of all the specialty-specific prevailing charges in the locality. Hence, beginning in 1992, Medicare payments to all physicians who provide a service in a locality will be the same for that service regardless of the physician's specialty. For some physicians, this adjustment to their prevailing charges will either accelerate or slow the change to the RBRVS amounts.

Step 2: First Year Increases and Decreases. Beginning in 1992, the Medicare payment for a service will be referred to as the "recognized payment amount;" this term replaces CPR's "Medicare allowed amount" and includes the required 20 percent beneficiary copayment. In 1992, services for which the Medicare adjusted prevailing charge is neither 15 percent higher nor lower than the RBRVS payment schedule will be paid entirely on the basis of the new payment schedule. Services for which the new payment schedule represents a change of greater than 15 percent will be increased or decreased *from the adjusted prevailing charge* by 15 percent of the payment schedule amount in 1992.

Step 3: The 1993-1996 Transition. From 1993-1995, payments for services that did not move entirely to their RVS amounts in 1992 will be incrementally increased or decreased using a blend of the 1992 recognized payment amount and the RBRVS (plus the annual update), with the proportion of the blend that is based on the new payment schedule increasing each year. In 1996, payments for all services will be based entirely on the RBRVS payment schedule.

Geographic impact

The major impetus behind the OBRA 89 payment reform was the strong support within the medical profession for reducing geographic variation in Medicare payments to levels supported by practice cost variation. Under the new system, nationally standardized Medicare payment amounts will be established, and these payments will be adjusted for geographic cost differences, which current data suggest are far below variation in current Medicare payments. Hence, even though the new payments will be geographically adjusted, there will be substantially less geographic variation in Medicare payments than under the current system.

Currently, a Medicare locality is the geographic area the carrier uses to determine prevailing charges for services. There are now 240 of these localities, which were developed by Medicare carriers, based on their knowledge of local medical practice and economic conditions. These locality boundaries have remaned relatively stable since inception of the Medicare program in 1965.

Medicare localities under the new Medicare fee schedule will most likely be revised. It is anticipated they wil follow state lines, except in 16 states, including Michigan, where there is a significant variation in practice costs. The PPRC is due to complete its recommendations by July 1, 1991, for Congress' evaluation and final decision.

The AMA is most concerned that current, reliable data are collected and used in the development of the GPCIs. Reduction in geographic variation to a level supported by demonstrated differences in physician's resource costs is a critical aspect of payment reform. The Model Payment Schedule published by HCFA in the September 1990 Federal Register, the RVUs for each component are multiplied by the locality GPCI for that component, the products are summed to get the total RVSs and this total is multiplied by the conversion factor.

Balance billing

As part of the new Medicare physician payment system, balance billing limits will be phased in from 1991 to 1993. Effective January 1, 1991, MAACs were replaced by a new system of "limiting charges." In 1991, the limiting charge is *the lesser of* (1) the *percentage* by which the physician's 1990 MAAC exceeded the 1990 Medicare allowed amount for unassigned claims or (2) 25 percent above the allowed amount. An exception was made for evaluation and management services, which are capped for 1991 at 140 percent of the non-par prevailing charge. In 1992, the limiting charge will be the lesser of this same 1990 MAAC percentage or 20 percent above the recognized payment amount. For 1993 and subsequent years, the limiting charge for unassigned claims will be set at 15 percent above the recognized payment amount for non-participating physicians.

MVPS/conversion factor updates

OBRA 89 defines the Medicare Volume Performance Standard (MVPS) as a desired rate of growth in Part B expenditures that will be established by Congress each year. In setting the MVPs, Congress will consider the recommendations of the HHS Secretary and the PPRC. The Secretary is directed to consult with physicians' organizations and to take into account the following factors in making a recommendation for each fiscal year:

- inflation;
- changes in the size and age composition of the Medicare population;
- changes in technology;
- evidence of inappropriate utilization of services;
- evidence of inadequate access to physician services; and - other appropriate factors.

HHS and the PPRC are also required to provide detailed analyses of expenditures, utilization, and access with their recommendations.

The MVPS should provide a useful benchmark for physicians and their organizations, for HHS and the PPRC, and for the Congress, and it will be an important consideration in payment update decisions. Although OBRA 89 specifies that update deliberations will begin at the full MEI, it requires HHS to monitor and report to Congress on the difference, if any, between the MVPS and actual expenditure growth and to consider this growth along with other factors in making its update recommendations.

Determination of a conversion factor is exceedingly complex, particularly since it must be budget neutral. If the conversion factor is set too high, Medicare Trust Fund outlays will be larger than anticipated and would increase the overall federal budget deficit.

HCFA does not believe that the MVPS will take care of volume increases, 1) because the default payment update can only

Continued from previous page

be reduced by up to two percent, the MVPS will not adjust for projection errors resulting in overpayment in excess of two percent; and 2) because the two-year interval between expenditures measured under the MVPS and payment updates, there could be permanent losses that could not be recouped under the default MVPS. For example, if, as a result of projection errors, payments were set too high by just two percent, permanent losses could exceed $1.6 for 1992 and 1993.

Fee Schedule Payment Formula

$$\text{Payment} = [(\text{RVUw} \times \text{GPCIw}) + (\text{RVUoh} \times \text{GPCIoh}) + (\text{RVUm} \times \text{GPCIm})] \times \text{CF}$$

where

RVUw = physician work relative value units for the service
RVUoh = overhead relative value units for the service
RVUm = malpractice relative value units for the service
GPCIw = geographic practice cost index value for physician work applicable in the locality[1]
GPCIoh = geographic practice cost index value for overhead applicable in the locality
GPCIm = geographic practice cost index value for malpractice applicable in the locality
CF = uniform national conversion factor

[1] This value reflects only one-fourth of the variation in physician work, as required by OBRA of 1989.

Budget cuts may distort the RVS

Most physician fees were frozen or reduced in 1991, with only evaluation and management services receiving a modest two percent increase. This is particularly significant because HCFA will use 1991 as the basis for calculating a "budget neutral" RBRVS fee schedule, which means this year's budget cuts will most likely lead to lower payment levels under the fee schedule.

Other key issues that remain to be resolved before the RBRVS phase-in is scheduled to begin include the monetary conversion factor that will translate relative value units into the actual fees that physicians will be paid.

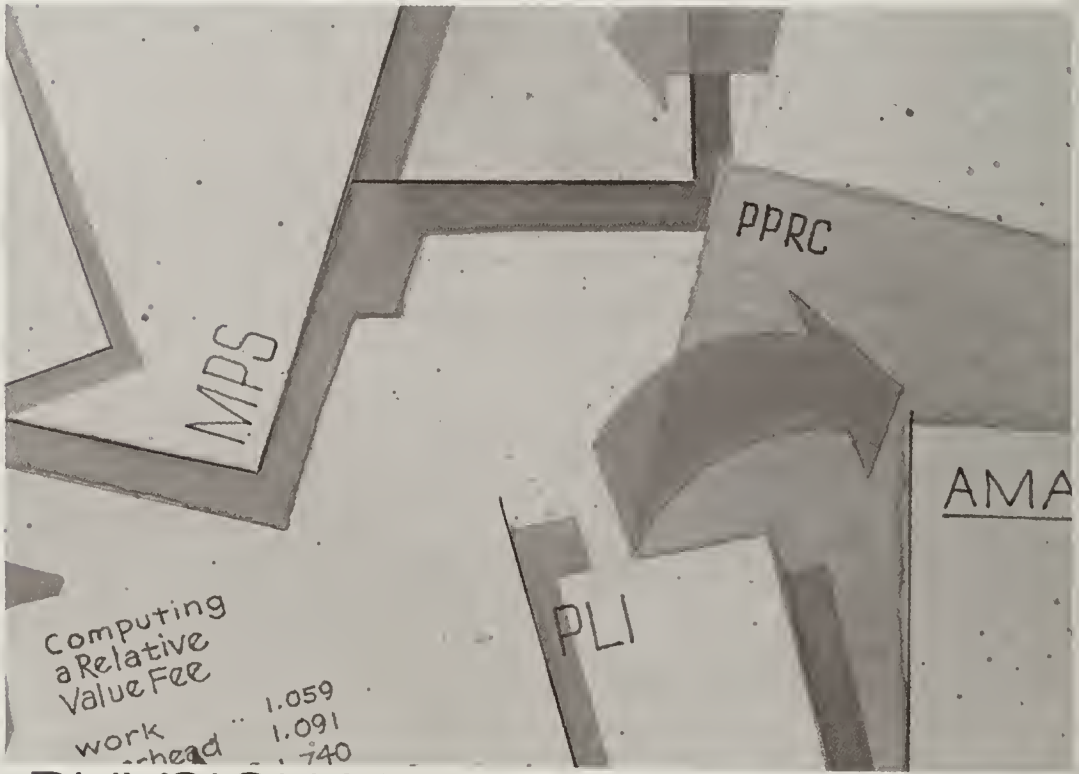
The Health Care Financing Administration is concerned that some physicians may increase the volume of their procedures and services to compensate for a decrease in fees and the agency plans to adjust the conversion factor before with a "behavioral offset." Such an adjustment may very well sabotage the new fee schedule and its goal of improving Medicare payments for undervalued services and have a significant impact on surgical specialties.

HCFA does not view the federal government's own Medicare Volume Performance Standards (MVPS), which are intended to counter inappropriate increases in the number of services, as a sufficient control. HCFA initially assumed a "behavioral offset" of 50 percent; that is, for every $1 reduction in physician payments there would be an increase in expenditures of $.50 due to a corresponding increase in utilization. It now appears that this behavioral adjustment may be scaled back, but it is likely that some adjustment will be retained.

Even if this issue is resolved to physician's satisfaction, there is still much concern among the medical community and the Blue Cross Blue Shield Association, many of whose members are Medicare contractors, that carrier underfunding and lack of time to debug a new system may lead to serious implementation problems.

These concerns have led the Physician Payment Review Commission to consider other possible implementation proposals. One would eliminate the five-year transition period and implement the RBRVS in a single year. This would reduce carrier workloads by eliminating the need for carriers to recalculate the blended rate each year of the phase-in period. The second proposal would delay the start-up date until July 1992, allowing carriers time to debug the system. ■

Rose Heald is reimbursement ombudsman for MSMS.



PHYSICIAN PAYMENT REFORM
in the Omnibus Budget Reconciliation Act (OBRA) of 1990

The Omnibus Budget Reconciliation Act (OBRA) 1990 contains a series of provisions designed to produce substantial budget savings by reducing Medicare payments to physicians. Although it is difficult to assess the immediate overall impact of these provisions, due to the complexity of the formulas, it is clear that the impact will vary across procedures, specialties and payment localities.

Described below is a selective summary of OBRA 90 provisions affecting Medicare Part B:

Updates for physicians' services

Percentage Increase in the MEI — A 2% Medicare economic index (MEI) update is allowed for primary care services furnished in 1991. No MEI update will be applied to non-primary care services in 1991. The MEI in effect for 1992 will be reduced by 0.4% below what would otherwise apply. Customary charge levels, except for primary care services and those determined as a percentage of prevailing charge levels, will be held at current levels for 1991.

Prevailing Charge Floor — For primary care services furnished on or after January 1, 1991, the prevailing charge floor will be increased from 50% to 60%. In transition to the full fee schedule, the adjusted historical payment basis for primary care services will be determined as if the 50% floor applied.

Volume Performance Standard for FY 1991 — In calculating the fiscal year 1991 Medicare Volume Performance Standard (MVPS), for both surgical and all other physicians' services, the HHS Secretary's projected base-line rate of growth will be reduced by 2 percentage points. Adjustments will be made to reflect the impact of legislative changes increasing or decreasing those expenditures.

Limitation on beneficiary liability

Limits on actual charges in 1991 for physicians' evaluation and management services will be increased from the current level of 125% of the prevailing charge to the lesser of 1) the updated 1990 Maximum Allowable Actual Charge (MAAC); or 2) 140% of the prevailing charge for the service in the locality.

The accompanying list includes all procedure codes that are considered evaluation and management services. (See listing at right.)

MAACs are replaced in 1991 by a new "limiting charge" for non-participating physicians. In 1991 and 1992, the limiting charge is specific to each physician but limited to no more than 25 percent over the prevailing charge in 1991 and 20% in 1992. In 1993 the fee schedule takes over,

Continued on next page

Evaluation and Management Services

Code	Description
90000	BRIEF SERVICE
90010	LIMITED
90015	INTERMEDIATE SERVICE
90017	EXTENDED SERVICE
90020	COMPREHENSIVE SERVICE
90030	MINIMAL SERVICE
90040	BRIEF SERVICE
90050	LIMITED SERVICE
90060	INTERMEDIATE SERVICE
90070	EXTENDED SERVICE
90080	COMPREHENSIVE SERVICE
90100	BRIEF SERVICE
90110	LIMITED SERVICE
90115	INTERMEDIATE SERVICE
90117	EXTENDED SERVICE
90130	MINIMAL SERVICE
90140	BRIEF SERVICE
90150	LIMITED SERVICE
90160	INTERMEDIATE SERVICE
90170	EXTENDED SERVICE
90200	BRIEF HISTORY AND EXAMINATION
90215	INTERMEDIATE HISTORY AND EXAMINATION
90220	COMPREHENSIVE HISTORY AND EXAMINATION
90225	HISTORY AND EXAMINATION OF INFANT
90240	BRIEF SERVICES
90250	LIMITED SERVICES
90260	INTERMEDIATE SERVICES
90270	EXTENDED SERVICES
90280	COMPREHENSIVE SERVICES
90282	NORMAL NEWBORN SERVICES
90292	HOSPITAL DISCHARGE DAY MANAGEMENT
90300	BRIEF HISTORY AND EXAMINATION
90315	INTERMEDIATE HISTORY AND EXAMINATION
90320	COMPREHENSIVE HISTORY AND EXAMINATION
90340	BRIEF SERVICE
90350	LIMITED SERVICE
90360	INTERMEDIATE SERVICE
90370	EXTENDED SERVICE
90400	BRIEF SERVICE
90410	LIMITED SERVICE
90415	INTERMEDIATE SERVICE
90420	COMPREHENSIVE SERVICE
90430	MINIMAL SERVICE
90440	BRIEF SERVICE
90450	LIMITED SERVICE
90460	INTERMEDIATE SERVICE
90470	EXTENDED SERVICE
90500	MINIMAL SERVICE
90505	BRIEF SERVICE
90510	LIMITED SERVICE
90515	INTERMEDIATE SERVICE
90517	EXTENDED SERVICE
90520	COMPREHENSIVE SERVICE
90530	MINIMAL SERVICE
90540	BRIEF SERVICE
90550	LIMITED SERVICE
90560	INTERMEDIATE SERVICE
90570	EXTENDED SERVICE
90580	COMPREHENSIVE SERVICE
90600	INITIAL CONSULTATION; LIMITED
90605	INITIAL CONSULTATION; INTERMEDIATE
90610	INITIAL CONSULTATION; EXTENDED
90620	INITIAL CONSULTATION; COMPREHENSIVE
90630	INITIAL CONSULTATION; COMPLEX
90640	FOLLOW UP CONSULTATION; BRIEF
90641	FOLLOW UP CONSULTATION; LIMITED
90642	FOLLOW UP CONSULTATION; INTERMEDIATE
90643	FOLLOW UP CONSULTATION; COMPLEX
90650	CONFIRMATORY CONSULTATION; LIMITED
90651	CONFIRMATORY CONSULTATION; INTERMEDIATE
90652	CONFIRMATORY CONSULTATION; EXTENDED
90653	CONFIRMATORY CONSULTATION; COMPREHENSIVE
90654	CONFIRMATORY CONSULTATION; COMPLEX
90699	UNLISTED MEDICAL SERVICE, GENERAL
90750	INITIAL HISTORY AND EXAMINATION; ADULT
90751	INITIAL HISTORY AND EXAMINATION; ADOLESC
90752	INITIAL HISTORY AND EXAMINATION; LATE
90763	INITIAL HISTORY AND EXAMINATION; EARLY
90764	INITIAL HISTORY AND EXAMINATION; INFANT
90801	ADMINISTRATIVE AND MEDICAL INTERP
90825	PSYCHIATRIC EVALUATION
90830	PSYCHOLOGICAL TESTING
90835	NARCOSYNTHESIS
90841	INDIVIDUAL MEDICAL PSYCHOTHERAPY
90843	INDIVIDUAL MEDICAL PSYCHOTHERAPY
90844	INDIVIDUAL MEDICAL PSYCHOTHERAPY
90845	MEDICAL PSYCHOANALYSIS
90846	FAMILY MEDICAL PSYCHOTHERAPY
90847	FAMILY MEDICAL PSYCHOTHERAPY
90849	MULTIPLE-FAMILY GROUP MEDICAL PSYCH
90853	GROUP MEDICAL PSYCHOTHERAPY
90862	PHARMACOLOGIC MANAGEMENT
92002	OPHTHALMOLOGICAL SERVICES, INTERMEDIATE
92004	OPHTHALMOLOGICAL SERVICES, COMPREHENSIVE
99062	EMERGENCY CARE FACILITY SERVICE
99064	EMERGENCY CARE FACILITY SERVICE
99065	EMERGENCY CARE FACILITY SERVICE
99160	CRITICAL CARE; INITIAL
99162	CRITICAL CARE; ADDITIONAL 30 MINUTES
99170	GASTRIC INTUBATION
99171	CRITICAL CARE; BRIEF EXAMINATION
99172	CRITICAL CARE; LIMITED EXAMINATION
99173	CRITICAL CARE; LIMITED EXAMINATION
99173	CRITICAL CARE; INTERMEDIATE EXAMINATION
99174	CRITICAL CARE; EXTENDED RE-EXAMINATION

Continued from previous page

with a limit of 15 percent over the fee schedule amount. See the accompanying examples for limiting charge calculations.

"Overpriced procedures"

Prevailing charge levels for the 244 services previously identified as "overpriced" by the Physician Payment Review Commission (PPRC), will be further reduced for 1991 by the same amount as reduced in 1990: the lesser of 15% or 1/3 of the amount they exceed the previously set locally adjusted reduced amount.

New physicians

Payment reductions for new physicians will be extended from a two-year phase-in to a four-year phase-in by capping their payments at 80%, 85% (current law), 90%, and 95% of the prevailing (1991) or RBRVS based payment amount for the first through fourth years of practice.

Exceptions will apply for primary care services or services provided in a rural area designated as a health manpower shortage area. The extension of this authority applies to physicians beginning their third or fourth years of practice after 1991 and 1992, respectively.

Assistants at surgery

Effective in 1991 and thereafter, payments for assistants at surgery will be limited to 16% of the allowance for the global surgical service.

Where the Secretary of HHS determines that an assistant is used in fewer than 5% of a national average of cases for a surgical procedure or class of procedures, Medicare payment will not be allowed for the use of an assistant.

Interpretation of electrocardiograms (EKGs)

Effective in January 1992, payment for the interpretation of EKGs (codes 93000, 93010, 93040, 93041 and 93042) will not be made where the EKG is performed and payment is made to a physician as part of a visit or consultation. For purposes of implementing the RBRVS, it will be assumed that this provision is effective in 1991.

Several national medical specialty societies are seeking the repeal of this provision. Repeal is unlikely, however, as it is estimated that this provision will save the federal government $725 million over five years.

Limiting Charge Calculations

1991 Example	**Dr. X**	**Dr. Y**
A. 1990 MAAC	$1150	$1400
B. 1990 Prevailing Charge	$1000	$1000
C. Percentage Difference Between A & B	15%	30%
D. 1991 Prevailing Charge	$1050	$1050
E. 1991 Limiting Charge (D increased by lower of C or 25%)	$1207.50	$1312.50
1992 Example	**Dr. X**	**Dr. Y**
A. 1991 Limiting Charge	$1207.50	$1312.50
B. 1991 Prevailing Charge	$1050	$1050
C. Percentage Difference Between A & B	15%	25%
D. 1992 Fee Schedule Amount	$1100	$1100
E. 1992 Limiting Charge (D increased by lower of C or 20%)	$1265	$1380
1993 Example	**Dr. X**	**Dr. Y**
A. 1993 Fee Schedule Amount	$1200	$1200
B. 1993 Limiting Charge (A increased by 15%)	$1380	$1380

* *Physicians may round the limiting charge to the nearest dollar if it is done consistently for all services.

Reciprocal billing arrangements (cross coverage)

Payments will be made to the physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional reciprocal basis if:

1) the first physician is unable to provide the visit services; 2) the individual has arranged or seeks to receive the visit services from the first physician; 3) the claim form submitted to the carrier includes the second physician's unique identifier and indicates that the claim is for a "covered visit and related services;" and 4) the visit services are not provided by the second physician over a continuous period of longer than 60 days.

Study of prepayment medical review screens

The Secretary of HHS is required to study the impact of the release of prepayment review screen parameters on physician billing and submit his findings to Congress by October 1, 1992.

Practicing Physicians Advisory Council

A new Practicing Physicians Advisory Council will be appointed by the Secretary of HHS. Appointments will be based upon nominations submitted by organized medicine.

The Council will be composed of 15 physicians, each of whom has submitted at least 250 Medicare claims in the previous year, and at least 11 of whom are MDs or DOs. The Council will meet once during each calendar quarter to discuss proposed changes in regulations and carrier manual instructions relating to physician services, as identified by the Secretary.

Both participating and non-participating physicians will be included on the Council, as will physicians practicing in rural and underserved urban areas.

Comparability

The comparability provision contained in the Social Security Act was repealed, effective January 1992, once the RBRVS is scheduled for phased-in implementation.

Comparability, which prohibits a Medicare carrier from paying more for a service than does the company for its private business, has impacted only four states, including MIchigan Pennsylvania, Alabama and western New York.

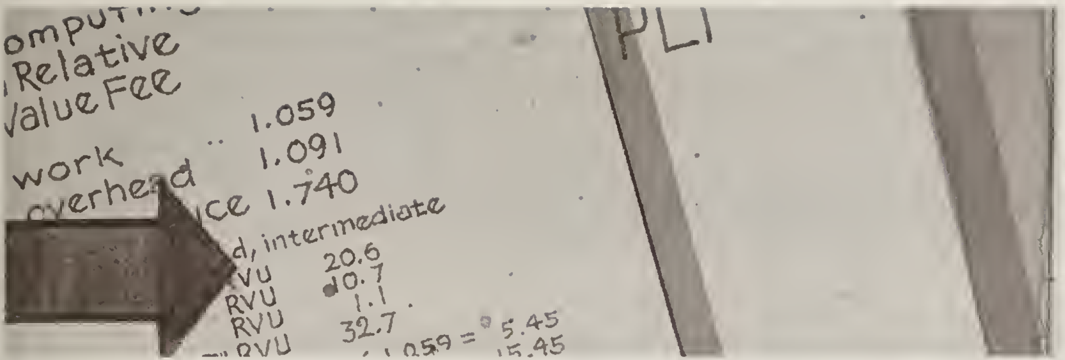
Directory of Unique Physician Identification Numbers (UPINs)

HCFA is scheduled to publish a directory of UPINs by March 31, 1991. The directory will include UPINs for all physicians requesting payment under Medicare and will provide name, provider number and billing address. It is still uncertain when Medicare will begin to require UPINs of referring and ordering physicians on claim forms.

Other provisions

There are many other provisions included in OBRA 90 impacting Medicare Part A, peer review organizations, hospital graduate medical education, community health centers, HMOs, and Medicaid. ■

—RBH



CPT CODING REVISIONS

necessary to RBRVS implementation

Significant revisions to the AMA's Current Procedural Terminology (CPT) are key to timely implementation of the new Resource Based Relative Value Scale (RBRVS) Fee Schedule, which will standardize Medicare reimbursement for physicians throughout the nation. The revisions must be in place to meet the January 1992 start-up date of the RBRVS.

The most important revisions are changes to the CPT codes for evaluation and management services, or visit codes, now listed in the CPT 90000 series. These codes represent approximately 35% of physician payments under the Medicare Part B program.

Background of revision process

The comprehensive revision process began about two years ago by the American Medical Association's CPT Editorial Panel, with input from the following groups:

CPT Panels Ad Hoc Committee on Visits and Levels of Service;
National medical specialty societies;
The Health Care Financing Administration and the Harvard University RBRVS research team;
Representatives of the AMA's Councils on Medical Service and Legislation;
Direct communications with hundreds of practicing physicians; and
A special consensus panel convened jointly with the Physician Payment Review Commission (PPRC).

Elements of the new coding system

The structure of the new system is very similar to that of the current CPT coding system, with several key differences.

Under the new system, a "time factor" will be incorporated into descriptions of the levels of service. A recommendation currently under consideration is the inclusion of "floor time" (the time a doctor spends on a hospital inaptient's unit or floor), as well as "face-to-face" time for office visits and consultations with the patient.

Time is proposed to be included as one element of the descriptor to meet the unique requirements of the new Medicare Fee Schedule, which was approved by Congress in 1989. Under the fee schedule, one relative work value must be assigned to each procedure code, and this value must appy to physicians in all specialties in all regions of the country.

The second key difference in the new system is more precise descriptors for such terms as new versus established patients, consultation, concurrent care and patient referral; as well as more precise descriptors for each class of service (e.g., office, hospital, nursing home, emergency department).

In consideration of what makes one visit longer or shorter than another, there will be direct incorporation of the nature and complexity of patients' problems as a key element in the visit descriptors.

In addition, the AMA has recommended the incorporation of site of service directly in the coding system (using the five site groups currently in CPT) rather than relying on the "place of service indicator" on the claim form. This would create 12 classes of visits allowing payment per level of service to vary, reflecting difference in effort and practice costs for different types of visits and sites of visits.

Pilot testing

The CPT Editorial Panel has approved generic descriptors for office and outpatient medical services, inpatient hospital visits and consultations that will be pilot tested beginning January 1991.

However, according to the AMA, specialty specific examples, which will assist physicians in application of the generic descriptors, are under development and will be an important component of the revised coding system, both for pilot testing and implementation purposes.

Advantages of the new system

The clarity and specificity of the new system will offer physicians and their office staff several advantages, including:

- It will be easier to select the proper CPT code;
- It will help assure that physicians receive the correct payment for their evaluation and management services;
- It will allow more uniform interpretation by physicians, payers and patients, thus reducing such problems as automatic downcoding and medical necessity review, which are associated with coding questions.
- It will provide appropriate reporting mechanisms for "unusual or outlier" patient/physician encounters.

Conclusion

The pilot testing program is scheduled for completion in April 1991 and results of the study will be published in May. In addition, HCFA will use the study results to complete its report to Congress, due July 1, 1991, on the advisability of including time in the coding system.

Once the final visit codes are available, the AMA will work with state medical societies and others to develop educational programs that will ensure a smooth transition to the new visit coding system. ■

—RBH

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THE BLUES'
NEW

Physician Participation Agreement

MSMS tackles contractual concerns, hopes for change

By Claudia Skutar

For the first time in more than 50 years, Blue Cross Blue Shield of Michigan (BCBSM) has developed a new physician contract. Titled the Physician and Professional Provider Participation Agreement, that contract, which took effect Jan. 1, has been the subject of much debate between MSMS and BCBSM.

MSMS has participated in ongoing discussions with BCBSM on many areas of the contract to ensure that physicians' best interests are represented.

"We worked for more than a year to obtain the best possible versions of the contract provisions that BCBSM required," MSMS President Susan H. Adelman said.

Doctor Adelman explained that there is a long background of difficult relations between MSMS and BCBSM. Gary D. Maynard, MD, chairman of the MSMS Liaison Committee with BCBSM, agreed with that assessment.

"I would characterize the relationship between MSMS and BCBSM as guarded, primarily because of the lack of trust between the two organizations," said Doctor Maynard.

However, during the past five years, the two organizations have developed a better working relationship, partly because of BCBSM efforts to improve its provider relations, according to Doctor Adelman.

"They do seem to be making an effort to obtain our constructive criticisms and to act on them," Doctor Adelman said.

One way in which BCBSM has attempted to improve provider relations is to seek physician input on the development of the new contract. That included input at statewide focus group meetings.

"BCBSM set up meetings around Michigan to allow senior BCBSM staff and board members to listen to what physicians had to say about the BCBSM and the contract," Doctor Adelman said. "BCBSM informed us later that those meetings helped shape their philosophy in putting the contract together."

Unresolved concerns

Still, despite MSMS input on the contract's development, there are unresolved concerns about a number of areas.

In a legal commentary on the contract, MSMS Legal Counsel Richard D. Weber, termed the document "comprehensive, containing 20 separate sections and nine addenda." Weber outlined in that commentary several important areas for physicians to consider when making a decision to sign the contract.

"Specifically, I would like to see improvements in the areas of medical necessity, appeals, billing for noncovered services, departicipation policies, supervision and timely payment to physicians," said Weber. "All of these and other areas are currently before the Physician Contract Advisory Committee."

That committee is a mechanism created by the new contract to provide a means for ongoing physician input.

"We're hoping through this committee to effect several important changes in the contract," Doctor Adelman said.

One item under discussion is the language in the section on determination of medical necessity, she said. The new contract says that authority rests with BCBSM, while under the old contract, the courts had agreed that physicians determined medical necessity. MSMS is working through the committee to change the language so that authority will again be clearly retained by physicians.

"Physicians are the only ones who can determine what's medically necessary," said Doctor Maynard. "Somehow there's got to be agreement that physicians determine medical necessity, while at the same time they pay attention to the inappropriate utilization of medical care."

MSMS not alone

MSMS is not alone in pressing for change in the new BCBSM contract. Attorney Andrew B. Wachler, of the law firm Wachler and Kopson, Detroit, filed an administrative appeal before an independent hearing officer of the Insurance Bureau against the BCBSM Provider Class Plan for 1987-1988. The appeal claims that the company did not meet the goals required by law.

Under Public Act 350 of 1980, which regulates BCBSM, the company is required to meet three goals: access to health care, quality of health care and cost containment. By law, BCBSM must file an annual provider class plan with the insurance commissioner to report whether it met those goals during the year. However, the plan cannot be regulated by the commissioner until at least two years after filing. The insurance commissioner determined last August on reviewing the 1987-1988 Provider Class Plan that BCBSM did not meet the cost containment goal, but that its failure to do so was "reasonable."

Wachler filed the appeal, along with attorney Gilbert M. Frimet of Southfield, because of concerns with several areas of the contract, including medical necessity and the physicians' appeals process.

"Under the new contract, BCBSM determines what is medical necessity, while under the old contract, physicians did," said Wachler. "Our position is that physicians. . .should have that responsibility. That doesn't mean that it should go completely unfettered."

He also expressed concern with BCBSM's ability under the new contract to terminate a physician at any time for any reason.

"Public Act 350 provides certain rights to physicians. . .if they are participating physicians or participating on a case-by-case basis," said Wachler. "BCBSM has a contract in effect that allows them to terminate the rights given to physicians by the Legislature."

MSMS, while recognizing that, feels that it is important for physicians to retain the right to terminate without cause with 60 days notice. It also feels that, if that is left in, BCBSM will insist on the same right, according to Doctor Adelman.

A different approach

While Wachler has concerns similar to those of MSMS, he differs from MSMS in his approach to their resolution. MSMS seeks to resolve contract problems through the Physician Contract Advisory Committee, while Wachler is relying on his appeal to force BCBSM contract changes.

"The Physicians Contract Advisory Committee is an effective tool because we are working on changing actual contract language right now. We also are identifying issues, and breaking down the steps to their resolution into components," said Doctor Adelman. "That allows us to make

Continued on next page

Continued from previous page

the necessary changes right now, without having to obtain the right to address these issues through litigation."

"We're both trying to improve the relationship for physicians," said Wachler. "Our focus is more on preserving physician rights through Public Act 350. BCBSM has the legal right to designate who's on the committee and what the committee can do. The committee has no binding legal power. It can only give advice and consultation."

According to Wachler, BCBSM can, under the contract, unilaterally modify the document with input from the committee. Although he acknowledged that BCBSM won't modify it without talking with the committee first, he said the contract doesn't require it.

"Given that legal structure. . .BCBSM has unfettered discretion," said Wachler. "They can do whatever they want."

Wachler said, if the appeal is successful, the BCBSM contract currently in effect will be thrown out.

"The burden of proof is on BCBSM to show that it's meeting the three goals," Wachler said. "If BCBSM doesn't meet the burden of proof, that would mean it's not meeting its goals and the contract would not be in effect."

If that happened, Wachler explained, the old contract would resume effect until a new one could be developed. BCBSM would have six months to submit a new provider class plan, which must resolve the deficiencies cited by the independent hearing officer. The hearing officer or the insurance commissioner would then have three months to determine whether the proposed BCBSM plan actually corrected the deficiencies. If either official ruled the plan unsatisfactory, the independent hearing officer would then develop a new provider class plan.

"If Wachler can reopen consideration of the Provider Class Plan, he hopes to argue subsequently that, for technical reasons, the contract is not valid," said Doctor Adelman. "Then he hopes to obtain the right to change the contract. In the deliberations of the Physician Contract Advisory Committee, while the Blues are not bound to act on the advice of the physicians, if they do not do so in good faith, they will destroy the new relationship they are hoping to build with the physician community."

Although MSMS believes the Physician Contract Advisory Committee is a better forum for ironing out problems in the BCBSM contract, it still sees merit in Wachler's appeal.

"We're supportive of Wachler — he's enhancing our position in many areas," said Doctor Maynard.

Modification questionable

"To the extent the case results in improving the new physician contract, it would be beneficial to physicians," said Weber. "There is a fundamental issue as to whether or not the contract, which became effective on Jan. 1, can be modified based upon a determination relative to the Medical Doctor Provider Class Plans which covered the years 1987-1988."

"We caused many important changes to be made in the contract before it was completed, and now that the contract is out, we share Wachler's concerns about the remaining problems," said Doctor Adelman.

However, once Wachler is through with the lengthy appeals process, what he'll have accomplished won't be much different than what the Physicians Contract Advisory Committee is currently working to achieve, she said.

"It's not clear that there are a lot of gains to be made in the physician appeals process as a result of Wachler's case," said Doctor Adelman. "Also, the possibility of Wachler's case eventually improving the pay level for physicians doesn't look good. In fact, the one clear deficiency that the Blues admit is their failure to meet the cost containment goal of the last provider class plan. They certainly will not achieve it if they increase physician payment."

Weber explained that, to the extent the appeal is designed to improve the physicians' contract, it is consistent with MSMS' objectives.

"Although the Physician Contract Advisory Committee process may be a more direct route to resolving contractual concerns, the appeal represents a valuable alternative process which could also result in achieving some of the desired changes," said Weber.

This remains to be seen as the committee moves forward in its contract talks.

Anxiety looms

"Contract problems bring up payment and service issues," said Doctor Maynard. "Add to these issues a lack of trust, and you have a great deal of anxiety among physicians about how things will work out.'

Three meetings of the 16-member committee have been held to date to discuss physician concerns with the contract. The committee is composed of eight physicians (five from MSMS and three from the Michigan Association of Osteopathic Physicians and Surgeons) and eight BCBSM board members (who are BCBSM purchasers and subscribers).

The last meeting was held Feb. 27, with medical necessity as the number one agenda priority. At the time this article went to print, the contract language for medical necessity was under revision. The role of specialty societies in setting review process criteria also was discussed at that meeting. Previous meetings resulted in the committee establishing a mechanism for specialty societies to review exceptions to the direct supervision requirement of the contract, and BCBSM's agreement to pay interest on late payments at a 10 percent maximum per year.

Fee survey reviewed

Another item reviewed on Feb. 27 was the 1987 Blue Cross Blue Shield Association physician fee survey of five neighboring states, comparing Michigan physicians' professional fees to those of surrounding states for 459 selected procedures. The study, which was conducted by Arthur Young and Company, concluded that BCBSM average reimbursement rates were about 40 percent less than other BCBS plans surveyed. MSMS recently obtained the study through a Freedom of Information request made to Michigan's Acting Insurance Commissioner Dhiraj Shah.

According to the commissioner, BCBSM's lower physician reimbursement levels are due to increased utilization and certain ancillary service categories, particularly diagnostic radiology and other medical services.

The lesser reimbursement of Michigan physicians in comparison to those of the five neighboring states in the survey "has created anger" among physicians, according to Doctor Maynard.

Analyzing the survey has been difficult, he said, because MSMS only was able to obtain the portion of the total survey that Blue Cross Blue Shield of Michigan was required to release to the insurance commissioner. That was the part relating to cost containment.

"We don't have enough information to determine what's really happening," said Doctor Maynard.

The survey information that is available, and which revealed the reimbursement differentials in this region, has created physician dissatisfaction with the 9 percent increase in reimbursement levels provided under the new contract. The physicians of the Physicians Contract Advisory Committee are hoping to use that context to discuss physician reimbursement with BCBSM.

"BCBSM raised physician payments by 9 percent, but physicians are dissatisfied with this because of the information showing that reimbursement is 40 percent lower in Michigan than in five surrounding states," Doctor Adelman said. "A 9 percent increase will not make up this differential."

"Physicians will tolerate a lot of poor service for higher payments, or will accept good service and lower payments," explained Doctor Maynard. "However, when you have both low payment and poor service, you end up with disgruntled physicians."

Doctor Maynard cautioned against expecting too much to happen too quickly on all of the issues, especially reimbursement.

"These are old problems we're dealing with, and it may take a long time to resolve them," he said.

Some hope for change

Still, committee members have reason to believe that change will occur.

"I am advised by the physician members on the committee that there is some optimism that some of these issues will be resolved as a result of this process," said Weber. "The extent to which BCBSM follows the advice and consultation of the committee remains to be seen. The success of the entire contract might well be determined by the effectiveness of this committee."

"In many ways it behooves us to work closely with BCBSM," said Doctor Maynard. "However, it also behooves BCBSM to seriously discuss the issues that come before the committee so that physicians understand they are being taken seriously." ■

Claudia Skutar is Communications Specialist for MSMS.

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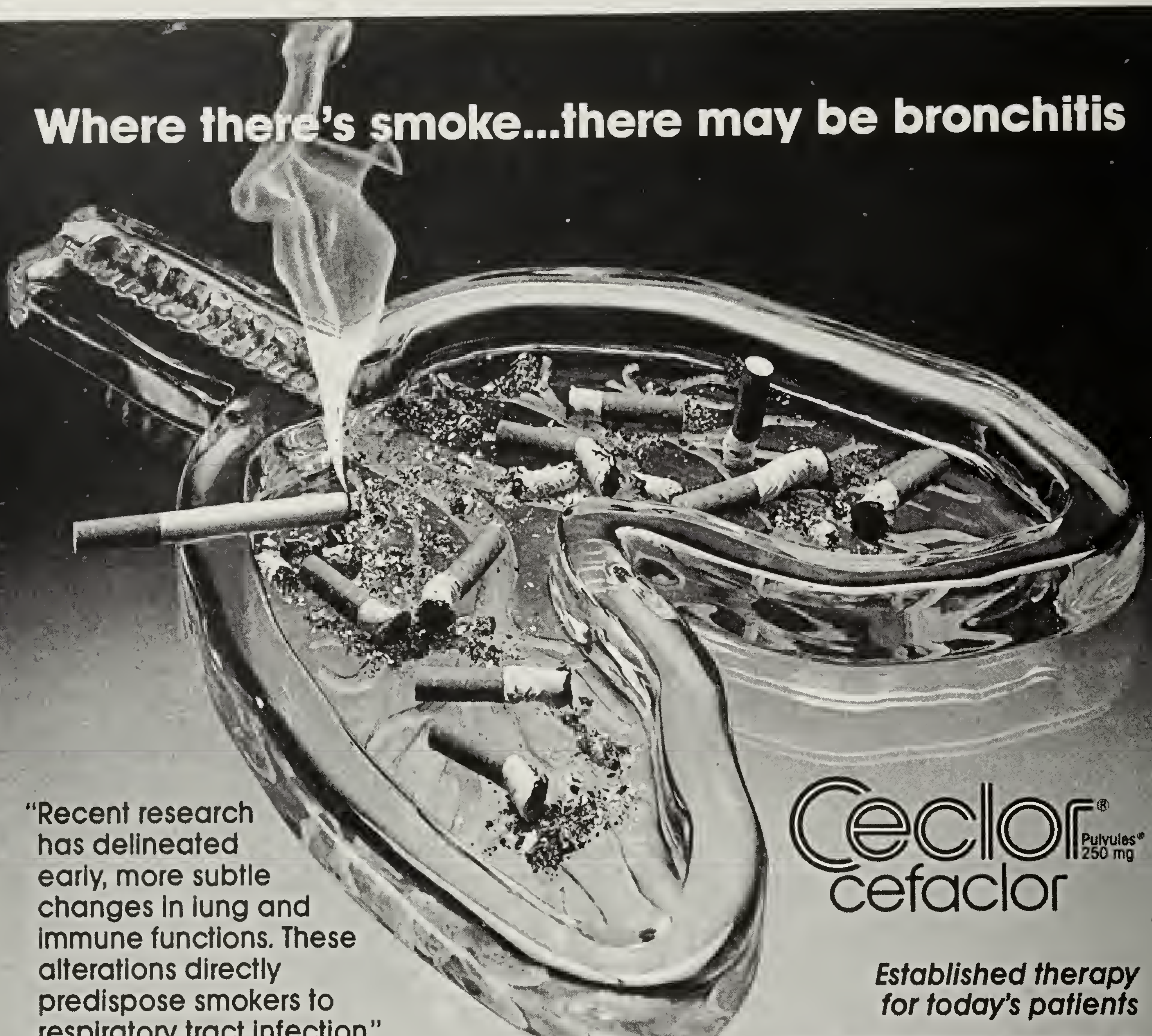

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
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Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
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PROFESSIONAL LIABILITY REFORM

MSMS sees opportunity for meaningful change

By Thomas E. Stone, MD

The Michigan State Medical Society believes there is a real opportunity for professional liability reform in Michigan. In our view, the likelihood of such reform has increased significantly during the past several months for three major reasons.

The most important factor is the election of Governor Engler, who has indicated that medical liability reform is his top health policy priority. Governor Engler appears to view liability reform as a key step toward improving access to health care, containing health care costs, and improving the quality of health care. Second, data released by Professor Robben Fleming, former Governor Blanchard's factfinder on liability, shows that Michigan hospitals and physicians pay extremely high professional liability premiums - just under $500 million annually. Finally, the recent Hutzel Hospital decision, in which the plaintiff won a judgment of $19 million, has focused tremendous media attention on the liability problem in Michigan.

Because of the improved political environment and the strong desire of Michigan physicians for meaningful liability reform, MSMS has made medical liability reform its top legislative priority for 1991.

At its January 9, 1991, meeting, the MSMS Task Force on Professional Liability carefully reviewed many liability reform alternatives including:

1. Limiting non-economic damages;
2. Reducing the statute of limitations;
3. Restricting contingency fees;
4. Requiring arbitration;
5. Creating a state legal expense fund to provide governmental liability coverage for physicians who provide obstetrical, prenatal, or pediatric services for Medicaid patients; and
6. Providing immunity for physicians who provide emergency care.

MSMS anticipates that many of these alternatives will be introduced in the Michigan legislature in 1991. The Task Force concluded that all of these alternatives are supportable by MSMS. The Task Force recommended that the primary legislative goal of MSMS should be passage of the Medical Liability Determination Act (the Michigan Alternative). The Task Force also strongly endorsed legislation that would allow a defendant in a professional liability case to file a countersuit under certain circumstances. On January 16, the MSMS Board of Directors endorsed the recommendations of the Task Force.

The Michigan Alternative is a comprehensive bill that would provide meaningful liability reform for all physicians in Michigan. In addition, many of the alternatives considered by the Task Force, including limiting non-economic damages and restricting the statute of limitations, would be addressed by passage of the Michigan Alternative.

The Michigan Alternative is based on model legislation developed by the Physician Insurers Association of America, the trade association of physician-owned liability insurance companies. Under this legislation, an injured party could either file a lawsuit or bring a complaint to a review panel, established by a new Medical Liability Determination Board (Board). Each review panel would be composed of a physician, a circuit court judge, and a public member. Whether a plaintiff files a lawsuit or brings a complaint to a review panel, *the plaintiff must prove fault* in order to recover damages. If fault is established, the plaintiff may be entitled to the following damages:

1. Incurred medical expenses;
2. Rehabilitative and occupational training;
3. Seventy percent of lost income capped at four times the state average weekly wage (about $80,000 a year);
4. Non-economic loss only for a permanent or severe temporary impairment, according to a schedule of benefits to be established by the Board with a maximum of $10,000 for each year of remaining life expectancy;
5. Dependent care capped at the state average weekly wage (about $20,000 a year);
6. Death benefits capped at approximately $200,000;
7. Lost income and dependent care paid to a spouse for up to seven years and to a minor until age 18; and
8. Attorney fees capped at 25 percent of all benefits (available only in the administrative proceeding).

The bill also would require that most future damages be paid over the expected time of the loss.

The Michigan Physicians Mutual Liability Company has estimated that enactment of the Michigan Alternative should eventually result in a significant reduction in malpractice premiums for Michigan physicians. "According to preliminary estimates, physicians may save between 15 percent to 30 percent in liability premiums if the Michigan Alternative is enacted as drafted," said Paul Stuhmer, MPMLC

Vice President, Research and Development.

Senator Dan DeGrow (R-Port Huron) will introduce the Michigan Alternative in February. He has indicated that the bill should move rather quickly through the Senate, but may face strong opposition in the House. Despite the expected House opposition, Senator DeGrow believes that enactment of the bill is "politically feasible."

The countersuit legislation approved by the MSMS Board would allow a defendant in a liability suit to file a countersuit for damages incurred by the defendant if:

1. The lawsuit is terminated in favor of the defendant;
2. The defendant suffers damages as a result of the lawsuit (The defendant would not be required to prove special damages; and
3. The plaintiff did not have a good faith belief in the existence of the facts upon which the claim was made, and the facts upon which the claim was made do not constitute either a valid claim under existing law or a good faith argument for the amendment or repeal of existing law.

While the Michigan Alternative and the countersuit legislation are the primary legislative goals of MSMS, we will strongly support any legislation that would provide meaningful liability reform. Moreover, MSMS will continue to work with the Michigan Department of Public Health to develop legislation that will provide governmental liability coverage to physicians who provide obstetrical, prenatal or pediatric services to poor women and children.

MSMS also to tackle contingency fee arrangements

In addition to pursuing legislative action, MSMS will petition the Michigan Supreme Court to modify its rules concerning contingency fee arrangements. Under the existing rules, attorneys may charge up to one-third of the amount recovered. The MSMS petition will urge that the Supreme Court adopt a sliding scale maximum contingency fee under which the percentage that an attorney is allowed to charge would decline as the amount recovered increases.

In pursuing liability reform, MSMS will work closely with the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons. MHA has already endorsed the Michigan Alternative. MAOPS was expected to endorse the Michigan Alternative as of press time. "MHA looks forward to working closely with MSMS and MAOPS to achieve our mutual liability reform goals," said Dennis Paradis, Vice President for Legislative Affairs of MHA. "MHA strongly supports the Michigan Alternative as a key component of a liability reform package."

Grassroots support vital

In conclusion, I want to reiterate my belief that a real opportunity exists for meaningful liability reform. At the same time, however, there is formidable opposition to meaningful liability reform, particularly in the Michigan House of Representatives. In order for MSMS to succeed, we will need strong grassroots support from Michigan physicians and their spouses. I am confident that physicians and their spouses will provide such support, and that liability reform will become a reality. ■

Doctor Stone is chairman of the MSMS Task Force on Professional Liability.

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Medical Inquirer

Michigan State Medical Society

Data and Trends Affecting Michigan Physicians

Issue 3 March, 1991

Michigan Has Highest Excess Deaths from Chronic diseases

In a study released by the Centers for Disease Control, Michigan ranked first in excess deaths for nine chronic diseases in 1986. Michigan's combined mortality rate for these nine diseases was 483 deaths per 100,000 population. The lowest mortality rate was in Hawaii at 305 per 100,000 population. The comparable mortality rate for the United States was 427 per 100,000.

Mortality Rates from Nine Chronic Diseases

East North Central States

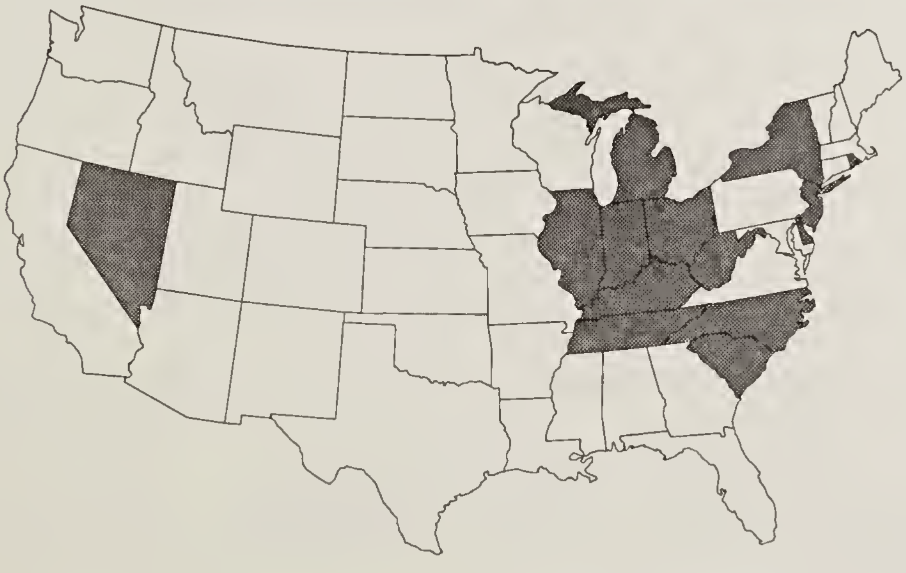
	Rank	Mortality Rate
Michigan	1	483
Ohio	4	469
Indiana	8	459
Illinois	11	455
Wisconsin	31	406

States with Lowest Mortality

	Mortality Rate
Hawaii	305
North Dakota	336
Utah	336
New Mexico	358
Minnesota	360

These diseases accounted for 52 percent of all deaths in the US in 1986. The diseases included in the study are stroke, coronary heart disease, diabetes, chronic obstructive pulmonary disease, lung cancer, female breast cancer, cervical cancer, colorectal cancer, liver disease and cirrhosis. A key to long-term control of health care costs may be in better preventive health education measures to control risk factors associated with these common causes of mortality.

States with 50 percent or Greater Excess Mortality from Nine Chronic Diseases



Center for Cartographic Research and Spatial Analysis
Michigan State University

SOURCE: Hahn, RA, et. al. Excess deaths from nine chronic diseases in the United States, 1986. *Journal of the American Medical Association.* 28 Nov 1990 264 (20): 2654-2659.

Health Resource Shortage Areas: Prenatal and Delivery Services

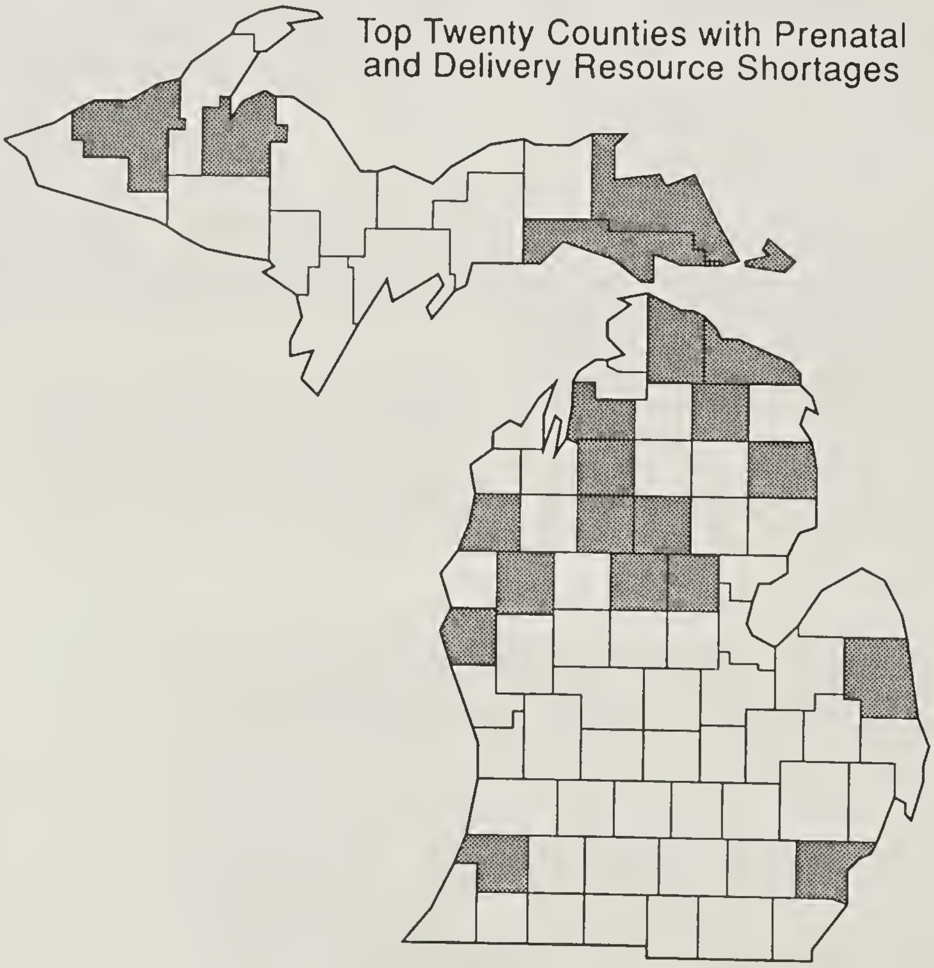
The Office of Health and Medical Affairs ranked Michigan counties according to relative need for prenatal care and delivery services. This ranking was designed to help the Michigan Department of Public Health determine priority areas for corrective action.

The Michigan Essential Health Provider Act established the following criteria for determining shortage areas for prenatal and delivery services:

- infant mortality rates
- appropriate physician to population measures
- percent of population eligible for Medicaid
- aggregate unemployment
- percent of practicing physicians who accept Medicaid
- Kessner Index — a measure of appropriateness of prenatal care

Top 20 Counties with Prenatal and Delivery Resource Shortages

Areas that rank high as resource shortage areas will benefit from programs that encourage physicians to relocate in these areas. Some areas may have an adequate physician supply but have more severe economic and health status indicators. In this circumstance, OHMA has suggested that the organization of existing resources should be addressed.


Top Twenty Counties with Prenatal
and Delivery Resource Shortages

Center for Cartographic Research and Spatial Analysis
Michigan State University

SOURCE: Michigan Department of Management and Budget, Office of Health and Medical Affairs.

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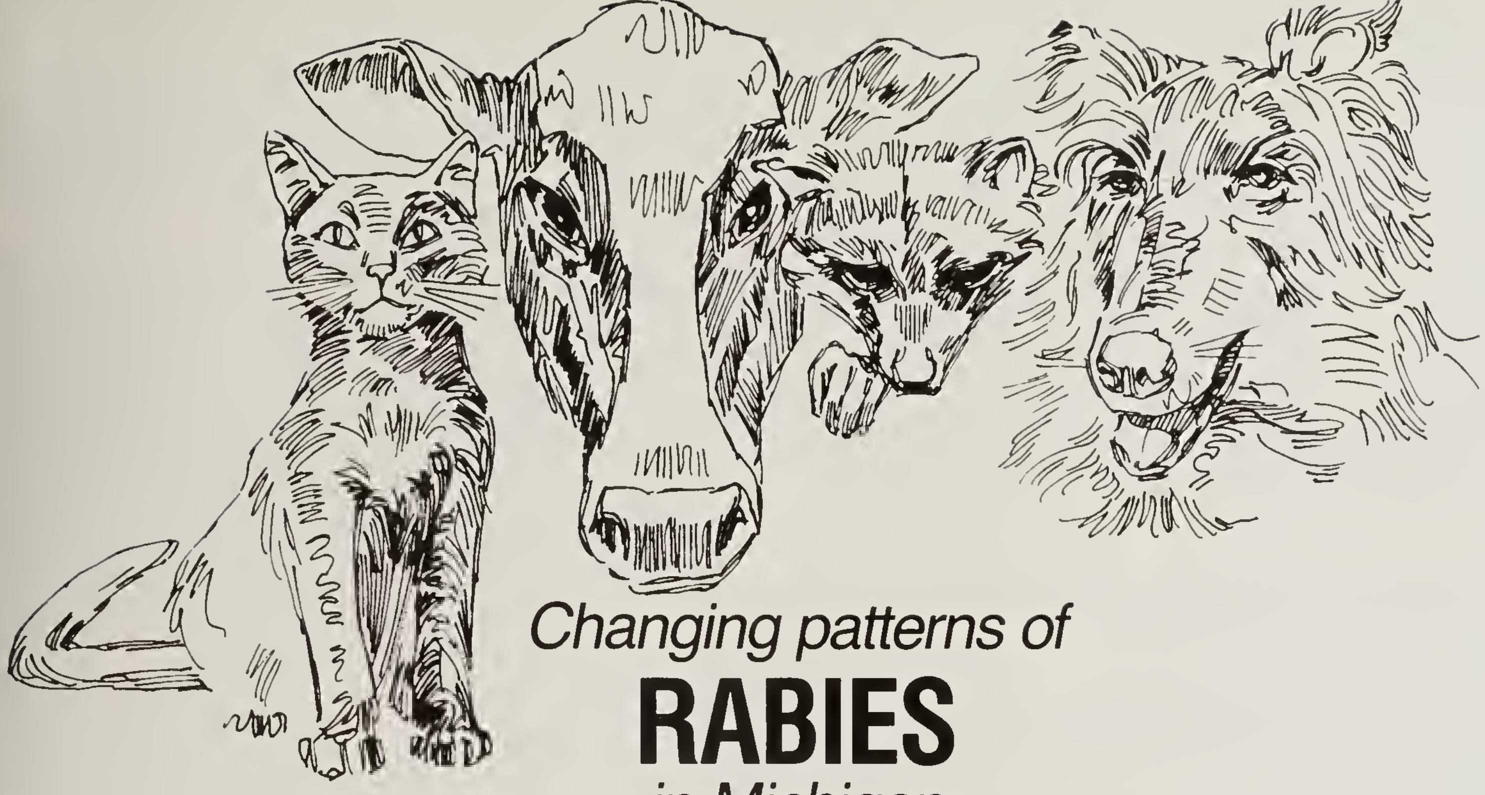

Changing patterns of RABIES in Michigan

By Byron S. Berlin, MD

Few diseases create fear in the human mind as does rabies. In the public view, rabies means mad dogs, animal bites and a gruesome death. Human exposure to animals which potentially carry rabies is common and knowing which animals in Michigan carry rabies could help physicians who are called on to care for persons with animal bites.

However, the Department of Natural Resources does not conduct systematic surveys of the numbers of animals in Michigan that are capable of transmitting rabies to man and, therefore, neither population changes in the various species nor the number of rabid animals can be precisely documented. On the other hand, the Bureau of Laboratories and Epidemiological Services, Michigan Department of Public Health, examines animals which, except in unusual cases, bite humans and are submitted by veterinarians or animal control officers for identification of those which are rabid. The numbers of animals submitted and the number found positive for rabies provided the basis for estimating the percent of rabies positive animals (the positivity rate) and the incidence of animal rabies in Michigan over the past 40 to 50 years.

A rural and suburban concern

In general, the data show that rabies which was largely an urban problem in Michigan, chiefly affecting cats and dogs until the mid-1940's, now is a rural and suburban concern. In 1940, 646 of 1,042 (62 percent) animals examined in Michigan were positive for rabies. In contrast, in 1985, only 29 of 1,710 animals (11 percent) were positive. Data concerning individuals species are available for the years between 1962 and 1982, and over that 20-year interval show dramatic changes in the amount of rabies in several species (see Table 1, page 48). For example, the positivity rate in skunks decreased, possibly due to a natural decrease in the size of the skunk population in Michigan and, consequently, a lessened opportunity for transmission of rabies between members of that species. In contrast, the decrease in the positivity rate for dogs and cats was probably the result of intensive animal rabies vaccination programs begun in the late 40's and early 50's. Rabies positivity in bats and raccoons did not appreciably change suggesting the natural history of rabies in these species differs from that in skunks, dogs and cats.

The species that had the highest positivity rate for rabies also changed over the interval in which data were collected (see Table 2, page 48). During the interval between 1943 and 1949, the dog, largely an urban animal, was the predominant rabies-positive species. Between 1954 and 1961, the skunk, a sylvatic creature, was the predominant animal, and between 1982 and 1988, the bat. Although rabies was consistently found in each species during the period reviewed, these shifts defined a changing pattern as animal rabies shifted from an urban to a sylvatic entity.

A time-related shift

The geographic distribution of rabies-positive species also showed a time-related shift. During the interval from 1943 and 1949, rabies-positive dogs were common from counties with large urban populations in Southern Michigan, but, at present, few rabid dogs are found in the larger cities. From 1954 to 1961, rabid skunks were submitted from counties widely scattered in Michigan. Today, they are found chiefly in Michigan's thumb region. In the 40's and 50's, rabies-positive bats were submitted chiefly from counties spread along and south of a line from Oceana County in the west to Tuscola County in the east. At present, rabies-positive bats are submitted chiefly from the population-dense counties in the Southeast part of the state.

During the four or five decades considered, rabid animals have been identified in 78 of 83 counties in Michigan. The apparently rabies-free counties — Baraga, Dickinson, Gogebic, Keweenaw, and Marquette, all in the Upper Peninsula — may, in part, owe their status to their sparse human population and the consequent reduced chance for human-animal contact. However, even counties in which rabies occurs with low frequency may experience a rabies epizootic, i.e., an epi-

Continued on next page

demic of rabies in a particular wildlife species. For example, in 1971-1972, a fox-rabies epizootic occurred in Chippewa County coincident with a similar outbreak in neighboring Canada. The epizootic is said to have been preceded by an increase in the size of the fox population in Chippewa County and it resulted in a drastic reduction in the size of the fox population as the outbreak "burned" itself out. Apparently, the fox population in Chippewa County has not recovered even now.

Control, prevention key

Because the factors that underlay the shifting pattern of animal rabies in Michigan are poorly understood, rabies control and prevention rank high as public health missions. Local health departments and animal control officials advise physicians and veterinarians about rabies prevention, enforce local laws and regulation concerning animals and communicate with state officials when their support is needed. Tactical support for local efforts is provided by three State agencies: The Departments of Agriculture, Natural Resources and Public Health. The latter provides consultative services to physicians, veterinarians and local health agencies, provides laboratory services for the diagnosis of rabies and, in addition, produces and distributes Rabies Vaccine Adsorbed, a new tissue culture rabies vaccine intended for use in humans. Animal vaccination program continue and are undoubtedly the principal reason why human rabies, which occurred at a rate of two to four cases per year in the 30's and 40's dropped to fewer than one case every six or seven years at present.

Although animal rabies in Michigan now is less than in the past, any wild animal, especially a carnivore, has the potential to expose humans to rabies. Consequently, a prudent person would avoid unnecessary physical contact with wildlife. Obviously, animal control personnel, hunters and trappers may be at greater risk of rabies than the general public and to offset that risk should be forearmed by obtaining pre-exposure rabies immunization. In addition, post-exposure rabies immunization should be given to persons exposed to proven rabid animals and to persons exposed to wild animals that cannot be examined in the laboratory. ■

Doctor Berlin is coordinating physician for the Bureau of Laboratory and Epidemiological Services, Michigan Department of Public Health.

TABLE 1
Laboratory Diagnosis of Rabies

Species	No. Positive 1962-1977	No. Examined (% +) 1978-1982
Skunk	$\frac{187}{459}$ (40.7)	$\frac{13}{184}$ (7.0)
Bat	$\frac{77}{1309}$ (5.8)	$\frac{46}{985}$ (4.7)
Dog	$\frac{38}{5960}$ (6.4)	$\frac{4}{1979}$ (0.2)
Cat	**$\frac{37}{6410}$ (5.7)**	**$\frac{2}{2043}$ (0.1)**
Cow	$\frac{40}{342}$ (11.6)	$\frac{7}{199}$ (3.5)
Raccoon	$\frac{1}{1117}$ (0.08)	$\frac{1}{458}$ (0.2)

TABLE 2
Changing Pattern Of Rabies In Certain Domesticated And Wild Animals in Michigan

	(Average Number Per Year) 1943-49	1954-61	1982-88
Domesticated			
Dog	232*	14.7	0.4
Cat	6.0	4.7	0.9
Cattle	12.9	3.7	0.7
Wild			
Skunk	0.1	20.7*	3.7
Fox	0	1.4	0.4
Raccoon	0.1	0.1	0.3
Bat	0	0.9	17.3*

*predominant rabies-positive species

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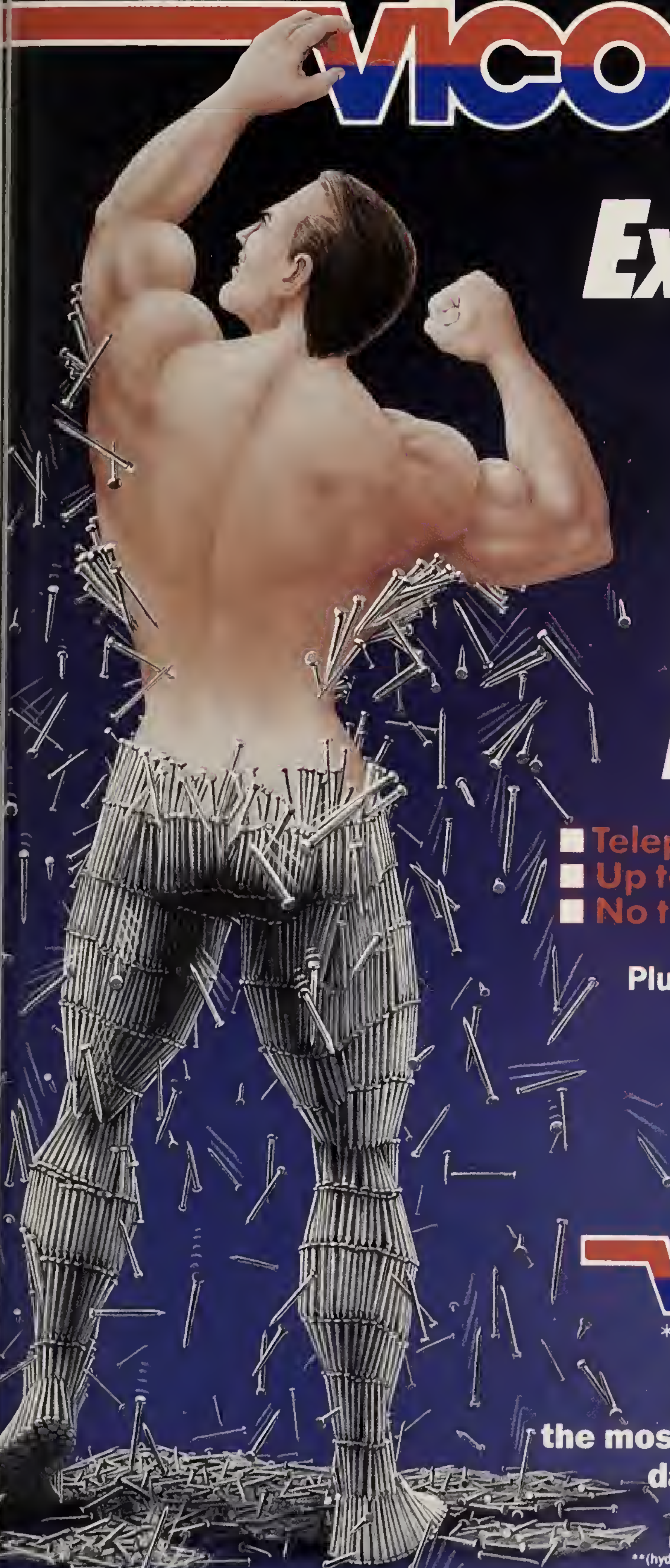

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

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Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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DEATHS

Paul M. Becker, MD
Franklin

Paul M. Becker, MD, an internist, died December 6. He was 61. Doctor Becker received his medical degree from the University of Bonn, Germany, in 1956. He interned at Detroit Harper Hospital in 1956 and served on staff of William Beaumont Hospital, Royal Oak. Doctor Becker had a private practice in the Birmingham area since 1962. He was a member of the Oakland County Medical Society and MSMS.

John H. Burger, MD
Franklin

John H. Burger, MD, an allergist, died December 13. He was 72. Doctor Burger was a 1948 graduate of Ohio State University School of Medicine. He served his internship at Ohio State University Hospital and his residency at Ford Hospital. He maintained an office in Southfield and served on staff of William Beaumont Hospital, Royal Oak. Doctor Burger served on the faculty of Wayne State University School of Medicine retiring 10 years ago. He was past president and member of the Michigan Allergy Society and a member of MSMS. A fellow in the American Academy of Allergies and the American College of Allergies.

Richard E. Dustin, MD
Tecumseh

Richard E. Dustin, MD, a general practitioner, died November 24. He was 71. Doctor Dustin attended Hiram College, Ohio, and received his medical degree from Ohio State University School of Medicine. He had a private practice in Tecumseh for 36 years retiring in 1983. He was on staff at Herrick Memorial Health Care Center and served as former chief of staff. He was a member of the American Academy of Family Medicine and MSMS.

Perry C. Gittens, MD
Traverse City

Perry C. Gittens, MD, a geriatrics physician, died December 18. He was 93. Doctor Gittens received his medical degree from Wayne State University College of Medicine in 1921. He served his internship and graduate training at Grace Hospital, Detroit. He served on staff of Grace Hospital moving to Sun City, Arizona, in 1975 when he retired from private practice. He was a life member of the American Academy of Family Practice, American Medical Association, Wayne County Medical Society and MSMS.

Francis S. Porretta, MD
Lathrup Village

Francis S. Porretta, MD, a general practitioner, died December 14. He was 90. Doctor Porretta graduated from the University of Michigan Medical School in 1925. He served his internship at Providence Hospital, Southfield, and became chief of staff. Doctor Porretta was a member of the American Medical Association, Wayne County Medical Society, American Society of Surgeons and MSMS.

Alexander B. Procailo, MD
Dearborn

Alexander B. Procailo, MD, a general surgeon, died December 16. He was 78. Doctor Procailo was a graduate of the Wayne State University School of Medicine. He had a private practice at the Garden City Medical Center from 1953 to 1980, when he retired. He served on staff at Eloise and Mt. Carmel hospitals in the 1940s and 1950s, Oakwood Hospital in the 1950s, and Annapolis Hospital from 1958 to 1982 during which time he was chief of staff in 1965-1966. He was a member of the Association of Military Surgeons of the United States, Wayne County Medical Society, American Medical Association, American Society of Abdominal Surgeons and MSMS.

John G. Waite, MD
Ann Arbor

John G. Waite, MD, a general practitioner, died December 22. He was 59. Doctor Waite had a medical practice in Ann Arbor since 1961. He was a member of the American Medical Association and MSMS.

Karl W. Weber, MD
Bloomfield Hills

Karl W. Weber, MD, an obstetrician/gynecologist, died December 27. He was 83. Doctor Weber graduated from the University of Michigan Medical School in 1933. He had a practice in the Metro Detroit area for 37 years. Doctor Weber retired in 1970 and moved from Grosse Pointe to Boca Raton, Florida. He returned to Michigan about eight years ago. He was a fellow of the American College of Surgeons and a member of MSMS.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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Battle Creek 49017

Gregor W. Blix, MD — U
350 Bronson Medical Center, E
Kalamazoo 49007

Donald W. Brown, Jr., DO — AN
1060 W. Norton Ave.
Muskegon 49441

Suzanne S. Cooper, MD — PD
2200 Springport Rd. #101
Jackson 49201

James I. Coughlin, MD — IM/GER
3000 Town Center #2160
Southfield 48075

Mark A. Dittenbir, MD — GS
250 Bronson Medical Ctr.
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Bret H. Doud, MD — AN
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Grand Rapids 49503

Gary M. Druskovich, MD — AN
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Saginaw 48603

Colette A. Gushurst, MD — PD
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Portage 49002

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Auburn Hills 48326

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Clifford L. McDonald, MD — IM
1990 Wealthy
Grand Rapids 49506

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133 E. Napier
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R. N. Maragiri, MD — IM
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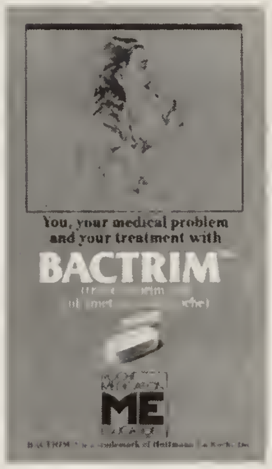
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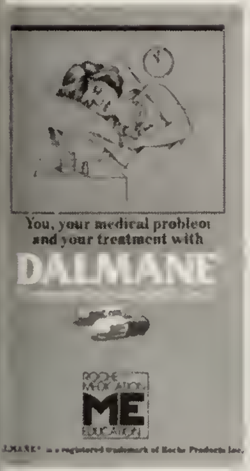
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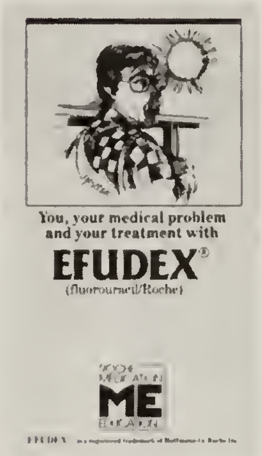
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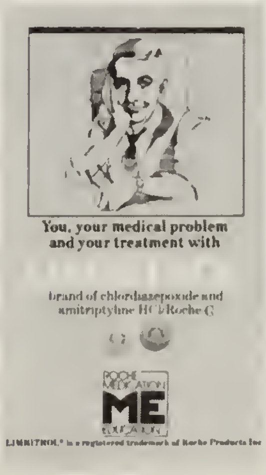
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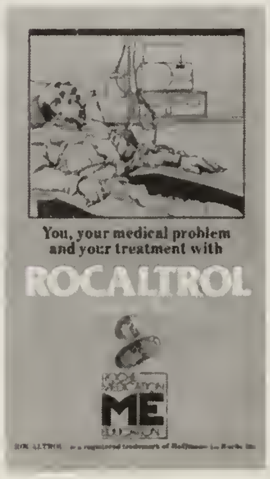
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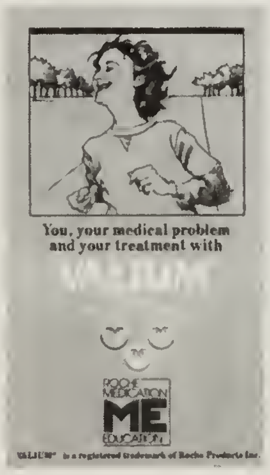
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MEETINGS

MSMS Meetings

March

7, MSMS Young Physicians Section, Annual Meeting, Kellogg Center, East Lansing, MI. Contact: Debbie Zannoth, Chief, Membership Department (517) 337-1351.

13-14, MSMS Maternal and Perinatal Annual Conference, Ritz Carlton, Dearborn, MI. Contact: Sherry Fent, Chief, Physician Education (517) 337-1351.

16, MSMS Hospital Medical Staff Section Annual Assembly, Dearborn Inn, Dearborn, MI. Contact: F.B. "Tom" Plasman, Manager, Physician/Hospital Relations, (517) 337-1351.

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

23, MSMS International Medical Graduates Annual Meeting, Ritz Carlton, Dearborn, MI. Contact: Judy Marr, Manager, Communications (517) 337-1351.

April

6, PSG, Michigan Society of Internal Medicine Spring Meeting, Embassy Suites Hotel, Southfield, MI. Contact: Caroline Kimmel, Executive Secretary (517) 336-7570.

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

Michigan Specialty Society Meetings

April

21-23, Uniting to Support Infants and Families in Crisis, University of Michigan Campus, Ann Arbor, MI. Contact: Kathleen Baltman (313) 577-5244.

National Specialty Society Meetings

March

7-12, American Academy of Orthopaedic Surgeons, Anaheim, CA. Contact: (708) 823-7186.

16-21, American Academy of Pediatrics - Spring Session, San Diego, CA. Contact: (708) 228-5005.

21-22, American Board of Medical Specialties Conference on Standards of Care and Recertification, Chicago, IL. Contact: (708) 491-9091.

23-25, Society of Magnetic Resonance in Medicine Workshop, Napa, CA. Contact: Society of Magnetic Resonance in Medicine, (415) 841-1899.

23-26, American Society on Aging, New Orleans, LA. Contact: (415) 543-2617.

April

11-13, American Society of Abdominal Surgeons, Tampa, FL. Contact: (301) 483-5471.

11-14, American College of Physicians, New Orleans, LA. Contact: (215) 351-2400.

21-23, National Council on Patient Information and Education, Washington, DC. Contact: (202) 347-6711.

21-25, American Association of Neurological Surgeons, New Orleans, LA. Contact: (708) 692-9500.

21-26, American Association of Immunologists, Atlanta, GA. Contact: (301) 530-7178.

21-27, American Academy of Neurology, Boston, MA. Contact: (612) 623-8115.

28-May/2, American Urological Association, Las Vegas, NV. Contact: (301) 727-1100.

29-May/3, American Pediatric Society, New Orleans, LA. Contact: (505) 764-9099.

May

3-6, Association of American Physicians, Seattle, WA. Contact: (609) 848-1000.

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gastroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-June/1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

March

9, Perioperative Ischemia Update. Location: Henry Ford Hospital, Buerki Auditorium, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Shelley L. Helton, Office of Continuing Medical Education, (313) 876-3073 or 1-800-888-4340. **Approved for:** 5.75 hours Category I Credit.

10-15, Emergencies In Medicine. Location: Yarrow A. Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

12,19, Vague But Persistent Heart Complaints. Location: Fisher Bldg., Detroit, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 6 hours Category I Credit.

15-16, Recent Trends In Electrophysiologic Assessment Intraoperative Applications. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

16, Second Annual Symposium on Medical Complications of Pregnancy: Autoimmune Disorders in Pregnancy. Location: William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital. **Contact:** Liz Kretschmann, Office of Continuing Medical Education, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073-6769, (313) 551-0429. **Approved for:** 4 hours Category I Credit.

19-23, Fifteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School; Department of Family Practice and The Michigan Academy of Family Practice. **Contact:** Julie Jacobs, Registrar, Towlsey Center, (313) 936-9800. **Approved for:** 35 hours Category I Credit.

19-23, Family Practice – 1991: Fifteenth Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 35 hours Category I Credit.

21-24, 11th Annual Advances In The Management of Infectious Diseases: Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

22, A Study In Hope: The Treatment and Management Of Alzheimer's Disease. Location: Fetzer Development Center, Western Michigan University, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies, Alzheimer's Disease and Related Disorders, Chapter of SW Michigan, and Kalamazoo Neurology. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo,

Continued on page 47

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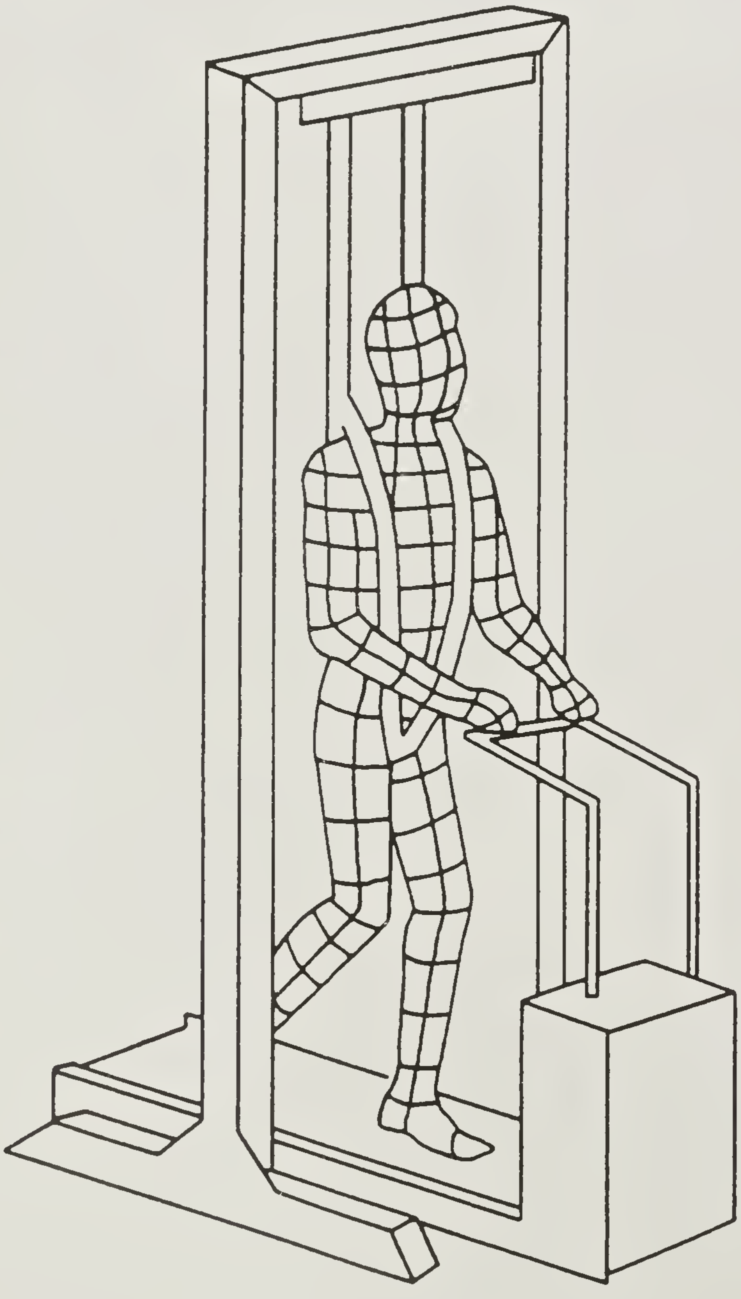

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CATEGORY I COURSES

Continued from page 45

MI 49001, (616) 383-7363. **Approved for:** 6.5 hours Category I Credit.

22, Primary Care – Clinical Problems in Otolaryngology Head & Neck Problems. Location: The Dearborn Inn, Dearborn Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202-2689, (313) 876-3073 or 800-888-4340. **Approved for:** 7.5 hours Category I Credit.

23-24, Regional Anesthesia: Anatomy & Techniques. Location: Wayne State University School of Medicine, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 12 hours Category I Credit.

26-April/2, Chronic Fatigue Syndrome: Fad or Fact? Contact: David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Detroit, MI 48202, (313) 872-7400. **Approved for:** 4 hours Category I Credit.

April

4-5, Challenges and Changes: Obstetrics and Gynecology In The 1990's. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University Of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-12, Ultrasound In Obstetrics And Gynecology. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 21 hours Category I Credit.

12, Sports Medicine. Location: Henry Ford Hospital - Buerki, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202-2689, (313) 876-3073 or 800-888-4340. **Approved for:** 6.5 hours Category I Credit.

12-13, Innovations in G.I. Management. Location: Amway Grand Plaza, Grand Rapids, Michigan. **Sponsor:** Saint Mary's Health Services. **Contact:** Catrina Patterson, Marketing Department, (616) 774-6458. **Approved for:** 10 hours Category I Credit.

17, Management of Terminal Illness: An Update. Location: Hotel St. Regis, Detroit's New Center Area, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202-2689, (313) 876-3073 or 800-888-4340. **Approved for:** 5.5 hours Category I Credit.

26-27, Evaluation and Management of Valvular Insufficiency. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Angela Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 764-2288. **Approved for:** 15 hours Category I Credit.

29-May/5, Advances In Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 33.5 hours Category I Credit.

May

3-5, The Treatment of Anxiety: A Psychotherapeutic Approach. Location: Hyatt Regency Suites, Chicago, Ill. **Sponsor:** Bar-

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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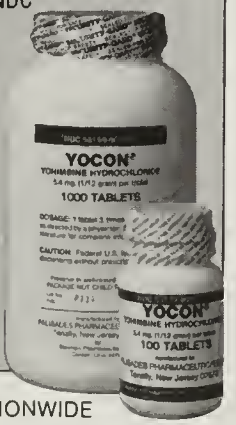

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Continued from page 47

Levav Association. **Contact:** James McCarthy, 200 Fisher Building, Detroit, MI 48202, (313) 872-1300. **Approved for:** 20 hours Category I Credit.

16-17, The Restenosis Summit III. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

17-18, 63rd Annual Ophthalmology Spring Postgraduate Conference: Lasers In Ophthalmology. Applications and New Developments. Location: University of Michigan, W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 13 hours Category I Credit.

20-22, Airborne Pollen and Fungus Spore Identification: A Hands-On Workshop. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Dept. of Postgraduate Medicine, P. O. Box 1157, Ann Arbor, MI 48106-9869 (313) 936-9800. **Approved for:** 17 hours Category I Credit.

June

5-7, 18th Annual Symposium on Current Topics in Blood Banking. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Dept. of Pathology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

13-15, Microscopic Endolaryngeal Surgery: New and Advanced Techniques of Diagnostic Treatment. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

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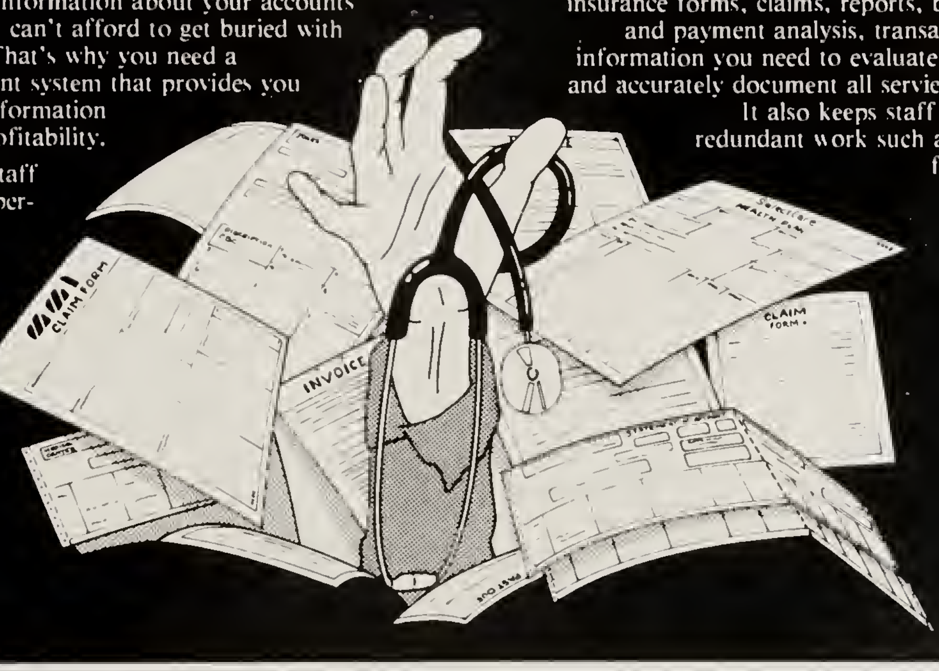

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ANESTHESIOLOGIST: Excellent opportunity to direct anesthesia at Bluffton Community Hospital, a 42-bed hospital located in a college community, one hour south of Toledo, one and one-half hour north of Dayton, off I-75. Shared call coverage. Board eligible, Board certified. Benefit package includes salary, malpractice insurance, health insurance, disability, and other fringes with moving allowance. Send resume to Administrator, Bluffton Community Hospital, P. O. Box 48, Bluffton, Ohio 45817 or call collect (419) 358-9010 or FAX (419) 358-7406.

ANESTHESIOLOGIST: Wanted for a full-time position in a community hospital. Pleasant environment. Competitive salary and early partnership. Send CV to P. O. Box 195, East Detroit, MI 48021.

CARDIOLOGY: Be a part of a thriving invasive cardiology **group practice** located in **Southern Indiana**. Affiliated with a 590-bed regional referral center. Competitive salary plus malpractice insurance and other physician perks. Send CV to: Don Hoit, 12161 Lackland Road, St. Louis, Missouri 63146 or call (800) 336-3963.

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DERMATOLOGIST, PSYCHIATRIST, ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE: A progressive, 126-bed, two hospital system is seeking the above specialties to establish practices in the **Iron Mountain** area of **Michigan's Upper Peninsula.** Must have BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully staffed special diagnostic department. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4500.

EMERGENCY PHYSICIAN: PORT HURON area. Low volume, 10,000 to 12,000 annual visits. Twelve-hour shifts. Salary or hourly. Send CV to Joseph L. Romain, 18161 West 13 Mile Road, Suite A-2, Southfield, MI 48076 or call (313) 642-9878.

FAMILY PRACTICE: Choose between-...several excellent family practice opportunities in Illinois, Wisconsin, Arizona and Maryland. Solo and group positions available with guaranteed salaries and competitive benefit packages. To discuss these positions in confidence, please call (800) 969-7715. Dan Jones. Gielow/Laske Associates, Inc., 306 North Milwaukee Street, Milwaukee, Wisconsin 53202.

FAMILY PRACTICE - CRYSTAL FALLS, MI: Central Southern Upper-Peninsula. Seeking a BE/BC Family Practice Physician. The physician will have the option of joining an existing practice or setting up a hospital sponsored practice. Service area of 8,000. Contact: H.B. Purdy, CEO, Crystal Falls Community Hospital, Michigan Ave. & Third St., Crystal Falls, MI 49920, or phone office (906) 875-4144; home (906) 875-4145.

FAMILY PRACTICE...HOSPITAL-SPONSORED CLINIC OPPORTUNITY. Dynamic, growth-oriented hospital in beautiful **North Central Wisconsin** is seeking Family Physicians to join a growing practice in a new facility. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact **Kari Wangsness, Associate, The Chancellor Group, Inc., France Place Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota 55435, (612) 835-5123.**

FAMILY PRACTICE OPPORTUNITIES: Michigan Primary Care Association, a network of Family Physicians with clinics statewide seeking BE/BC FPs. Outstanding opportunities for physicians wishing to provide the full spectrum of family care (OB not a requirement). Guaranteed salary with excellent benefits including malpractice insurance, ample vacation, and CME. Many locations are affiliated with FP Residency Programs, designated Loan Forgiveness sites, or near large lake communities. Contact: Lisa Hadden, Michigan Primary Care Association, 535 N. Capitol, Suite 4, Lansing MI 48933 or call (517) 484-8431 or (800) 752-7268.

FAMILY PRACTICE - Physicians seeking a BE/BC family practice physician for the **Norway, Michigan,** service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, MI 49870, (906) 563-9243 or office (906) 563-9255.

FULL-TIME, PART-TIME, AND LOCUM TENENS. GPs, PPs, and **Emergency Physicians** needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland, and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to or contact Euclid Medical Group, PC, 1420 Center Avenue, Bay City, MI 48708, (517) 892-1199.

GRAND RAPIDS: Progressive, established group of residency-trained, board-certified **emergency physicians** seek additional member. Must love emergency medicine and have sense of humor. Group has excellent practice of six years in newly-renovated department in 350-bed hospital. Full departmental status with excellent relationship with medical staff. Transcribed dictated charts and computer information systems in the department. Patient volume is 32,000. We have a high degree of participation in EMS system and also teach residents in the ED with house staff in all specialties except EM and PEDS. The initial compensation is over $125,000. Malpractice, health, and disability insurance as well as $2,000 education allowance the first year. Progressive

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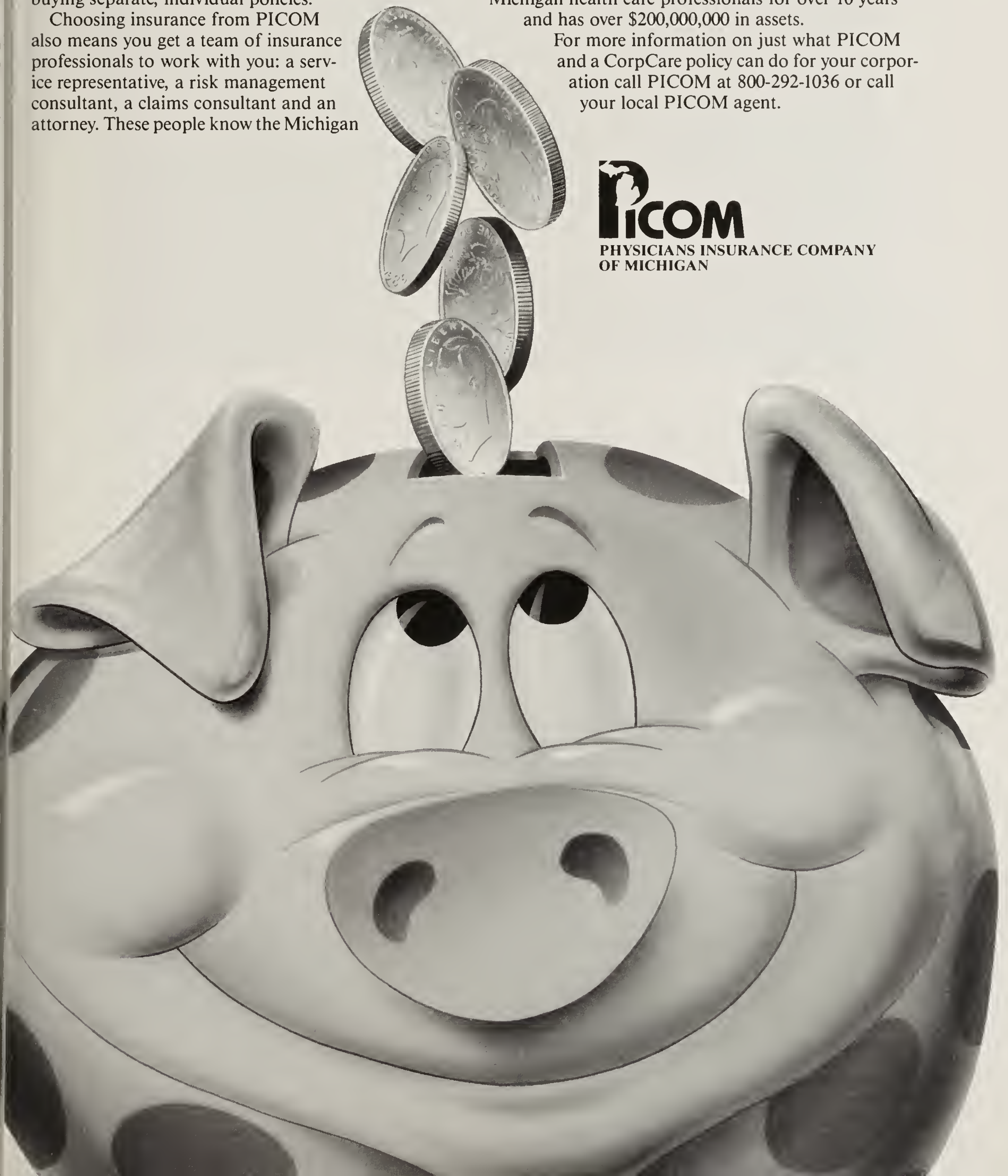

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community with arts and cultural opportunities. Beach, water, fishing, hunting, and outdoors activities. Send CV or contact: William C. Daney, MD, FACEP, Chairman, Department of Emergency Medicine, Saint Mary's Health Services, 200 Jefferson SE, Grand Rapids, MI 49503, (616) 774-6789.

GREATER DETROIT AREA: Looking for career-oriented emergency physicians board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Outstanding compensation including malpractice insurance. Benefit package available to full-time physicians. Contact: Sondra Hefflebower, Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684; (800) 253-1795 or in Michigan (800) 632-3496.

GUTHRIE CENTER - PANORA, IOWA: Currently needing two **Family Physicians** (with OB). Outstanding opportunities are available to place your skills to work in these two communities, with a combined population of 4,250 (including beautiful **Lake Panorama**). You will enjoy the clean living, low cost housing and high income potential. Share work and on call with other young family physicians. An array of other specialists rotate into the community hospital one-two days per month. A $140,000 loan repayment program is available for qualified medical education loans. An excellent compensation package awaits you. If you are interested in providing Quality Personal & Professional Medical Care to the patients in our service area, you should be interested in sending your CV to: Kenneth W. Turner, Recruitment Chairman, P. O. Box 603, Panora, Iowa 50216, (515) 755-2180 or Steven Bascom, MD, 502 Main Street, Guthrie Center, Iowa 50115, (515) 747-8348.

INTERNIST - FAMILY PRACTITIONER - PEDIATRICIAN (BE/BC Required). Due to our rapid growth and the expansion of our member population, SelectCare's MedExtend/HMO currently has full and part-time practice opportunities available at our **Sterling Heights, Troy and Warren** health centers. SelectCare's MedExtend/HMO is a progressive 80,000- member managed care organization, committed to high-quality comprehensive medical care and wellness promotion. Physicians who share this commitment and seek affiliation with an innovative health care organization and several of the finest hospitals in Southeastern Michigan are invited to forward a resume or CV to SelectCare's physician recruitment office at 363 West Big Beaver, Troy, MI 48084, or contact us at (313) 524-8002. We offer a highly professional working environment and an extremely competitive compensation and benefit package.

INVASIVE (NON-ANGIOPLASTY) CARDIOLOGIST - Four- physician, single- specialty cardiology group has an opening for a BE/BC invasive cardiologist. Fully-equipped cardiovascular surgery program is established. The practice serves a large and expanding regional referral area in Mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Centre Road, Suite 201, Saginaw, MI 48604.

JULY, AUGUST, SEPTEMBER - Various locum tenens positions available in emergency departments throughout Michigan. Combine vacation with work schedule. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684; (800) 253-1795 or in Michigan (800) 632-3496.

KALAMAZOO: Excellent opportunities available for BE/BC **family practitioners, internists and OB/GYNs.** Due to increasing patient volume, expansion of current practices is necessary. Opportunities include both hospital-based and group private practices leading to partnership. Competitive salaries, bonuses based on productivity, malpractice insurance and moving expenses. Bronson Hospital is a 442-bed tertiary care facility for southwestern Michigan. ICU, CCU, CSU, NICU, PICU as well as ACS certified Level I Trauma program. Strong subspecialty support. Affiliated with Michigan State University providing education to medical students and residents including FP and IM residency programs. Kalamazoo, located midway between Chicago and Detroit, offers diverse cultural opportunities. Lake Michigan's beaches and dunes only minutes away and numerous lakes, hills and forests provide boundless recreational activities. Excellent public and private schools, several colleges and major university further contribute to high quality lifestyle. Please send CV to Debra Hartman, Bronson Healthcare Group, One Healthcare Plaza, Kalamazoo, MI 49007 or call (800) 594-9022 or (616) 341-6331.

LAPEER, MICHIGAN – Seeking full-time and part-time **emergency department physicians** for busy 164-bed hospital. Residency training in emergency medicine or primary specialty required. Excellent compensation and attractive

Continued on next page

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The Director of the Women's and Children's Center of Excellence for Oakwood Health Services Corporation will be the organizational and public leader of the Center with responsibility for crystallizing and focusing the direction of the program. This will include:

- Reviewing and prioritizing the current "menu of service offerings".
- Achieving significant professional and community recognition which will assist in attracting quality providers.
- Leading the program development toward an organization-wide, integrated, price competitive and service-oriented Center.

The system has made a strong commitment to this program and has the available resources to make its dream happen. Oakwood Health Services Corporation has excellent facilities (flagship hospital is 600+ beds with over 4,500 deliveries annually) and an excellent payor mix with unmet patient demand.

The ideal candidate will be a physician who is Board Certified in a specialty focusing on women's and children's health. He/She will have achieved a quality clinical reputation, preferably in the development of significant, integrated programs known for excellence in women's and/or children's health.

For further information, please call Martin Farber, M.D. at (313) 593-7803 or send your CV to: **Martin Farber, M.D., Senior Vice President, Oakwood Hospital Corporation, 18101 Oakwood Boulevard, P.O. Box 2500, Dearborn, MI 48123-2500.** Equal Opportunity Employer.

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schedule. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Betty Looze, Emergency Consultants, Inc., 2240 S. Airport Road, Room 23, Traverse City, MI 49684 (800) 253-1795 or in Michigan (800) 632-3496.

MICHIGAN: EMERGENCY DEPARTMENT DIRECTORSHIPS, full-time and part-time opportunities available throughout the state. Rural and urban locations. Guaranteed hourly rate and malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 23, Traverse City, MI 49684 (800) 253-1795 or in Michigan (800) 632-3496.

MICHIGAN, SOUTHWEST: PHYSICIAN FOR EMERGENCY SERVICES. Community Emergency Departments, urgent care center, physician-staffed helicopter. Board eligible or certified in emergency medicine/internal medicine/family practice/general surgery or appropriate emergency medicine experience. Competitive salary and benefits. Excellent recreational area with abundant cultural opportunities. Send CV to Kalamazoo Emergency Associates, PC, 6600 S. Westnedge #101, Portage, MI 49002. May contact Lisa Semon (616) 329-3200.

ATTENTION PHYSICIANS

Deaconess Hospital of Evansville, Indiana and its affiliated physicians are actively recruiting qualified physician candidates to join existing medical practices of various specialties and locations.

Founded in 1892, Deaconess is a regional referral center and is the largest hospital in Southern Indiana, with 590 licensed beds and encompassing 14 city blocks. Deaconess has earned a strong reputation for providing compassionate care with advanced technology and continues to uphold a commitment to service and medical science.

Evansville is situated along the Ohio River near the southern tip of the state. With a greater metropolitan exceeding 250,000, Evansvile has all the benefits of a large city while maintaining a quiet "hometown" atmosphere. It's also conveniently located within three hours of St. Louis, Indianapolis, Nashville, and Louisville.

For more information,
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MINNESOTA communities seek **family physicians:** Private practice opportunities in attractive settings offer guarantees plus incentives, benefits, and hospital support. Locate your practice in Minneapolis, Richfield, Hopkins, Eden Prairie, Wayzata, Mound, Montgomery, Monticello, Lakefield, Litchfield, Springfield, or St. James. Contact: Jerry Hess, Abbott Northwestern Hospital, 800 East 28th. Street, Minneapolis, MN 55407 (800) 348-4921.

NEW YORK: FINGER LAKE REGION – Seeking **director** and full-time **emergency department physicians**. Excellent compensation, paid malpractice insurance, signing bonus, and optional benefit package. Contact: Karen Remai, Emergency Consultants, Inc., 2240 S. Airport Road, Room 23, Traverse City, MI 49684 (800) 253-1795 or in Michigan (800) 632-3496.

NON-INVASIVE CARDIOLOGIST – Four-physician, single specialty cardiology group has an immediate opening for a BE/BC non-invasive cardiologist. Echo, doppler, holter, and treadmill are established in-clinic. Full invasive and surgical programs are established. The practice serves a large and expanding regional referral area in Mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Centre Rd., Suite 201, Saginaw, MI 48604.

OPHTHALMOLOGIST BC/BE to join active general ophthalmology practice in suburb of Detroit. Option for partnership. Send CV to: Michigan State Medical Society, P. O. Box 950, Attention: SJD-203, East Lansing, MI 48823.

PEDIATRICIANS: BC/BE wanted for hospital-based pediatric practice in **Detroit**. Modern, new facility. Michigan licensure required. Send CV or resume to: David Ameen, Detroit Riverview Hospital, 7733 E. Jefferson Avenue, Detroit, MI 48214-2598, (313) 499-4100.

PRIVATE PRACTICE OPPORTUNITIES exist in **Southern Indiana** affiliated with a 590-bed hospital. Specialties include **Internal Medicine** and **Family Practice**. Competitive compensation plan and attractive partnership arrangement available. Send CV to Don Hoit, 12161 Lackland Road, St. Louis, Missouri 63146 or call (800) 336-3963.

PSYCHIATRIST/ADMINISTRATOR FOR VA PSYCHIATRY SERVICE CHIEF: The Department of Psychiatry, Wayne State University, and the VAMC Allen Park, seek a board **certified psychiatrist** to direct a 120-bed inpatient service and active outpatient Mental Health Clinic. The **Allen Park** VA has a strong commitment to quality care, teaching and research. Responsibilities include organization, administration and implementation of clinical and research activities in the areas of inpatient acute psychiatry, alcohol and drug treatment units, outpatient day treatment, drug dependence and mental health clinic programs. Candidate should be at/or eligible for an Associate Professor level appointment and have an excellent track record, with strength in the areas of leadership and organization. Contact: Michael K. Samson, MD, Chief of Staff, VAMC Allen Park, MI 48101, or call (313) 562-6000, extension 3327.

PSYCHIATRY OPPORTUNITY: Allen Park VA Medical Center, a 539-bed general acute care facility is seeking a BC/BE physician to join our professional staff. The Allen Park VA has a strong commitment to quality care, teaching and research. Interested candidates should forward their curriculum vitae to Michael K. Samson, Chief of Staff, VA Medical Center, Allen Park, MI 48101 or call (313) 562-6000, extension 3327.

RADIOLOGIST: Permanent position for **General Radiologist** that is board certified/eligible. Starting date in 1991 or 1992 is flexible. Present group of five general diagnostic radiologists practices at Marquette General Hospital (Regional Medical Center), a private office owned by the group, and two community hospitals. Diagnostic examinations total 100,000 plus annually. Practice includes; angiography and invasive procedures, Nuc Med, U/S, CT and MRI. Marquette General has 300 plus beds and is currently expanding. The hospital also has a family practice residency program. The radiology department has a GE CT-9800 and Signa 1.5T MR. The Marquette community has approximately 130 physicians and many specialties are represented. Marquette, Michigan is centrally located on the south shore of Lake Superior in the beautiful Upper Peninsula and is the home of Northern Michigan University. There is immediate access to all outdoor activities; hunting, fishing, skiing, boating, etc. We offer competitive salary, attractive early opportunity to become principal in professional corporation, ample allowance for paid CME and vacation, retirement plans and other fringes. Contact Doctor Bert Lara, Marquette Radiology Associates, PC, 1414 W. Fair Avenue, Marquette, MI 49855 (906) 225-3945.

RADIOLOGY/ORTHOPEDICS/FAMILY PRACTICE/PEDIATRICS/OB-GYN /INTERNAL MEDICINE/PERIPHERAL VASCULAR SURGERY: Several attractive opportunities in INDIANA, NEBRASKA, WISCONSIN and MICHIGAN. A variety of practice settings. Single, multi-specialty, or solo opportunities. Contact Bob Strzelczyk to discuss your practice requirements and these positions at (800) 243-4353. STRELCHECK & ASSOCIATES, INC.; 10624 N. Port Washington Road, Mequon, WI 53092.

WEST BRANCH: Full-time **emergency department** position available at moderate vol-

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ume facility located in beautiful northern Michigan. Attractive hourly compensation and malpractice insurance provided. Benefit package available to full-time physicians. Contact: Betty Looze, Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684; (800) 253-1795 or in Michigan (800) 632-3496.

WISCONSIN: 120-physician multispecialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE **pediatricians** to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, LaSalle Clinic, 411 Lincoln Street, Neenah, WI 54956 (414) 727-4276.

WOMAN INTERNIST: BC/BE desired for growing **primary care practice** in **North Oakland County.** Full-time/part-time, contact: Susan E. Coleman, MD, Medical Director, (313) 625-6660, Women's Health Center of Clarkston, Pine Ridge Place, 7650 Dixie Hwy., Clarkston, MI 48346.

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DEARBORN HEIGHTS-REDFORD-LIVONIA AREA: General Medicine.. Doctor slowing down. Volume still **over $400,000.** Beautiful building **totally financed by seller. BIRMINGHAM: Ophthalmology Practice**..Good location. All equipment and furnishings in place. **Volume over $1,000,000. PONTIAC: Internal Medicine** practice..Doctor has a **sub-specialty** in **Rheumatology** but not necessary for new doctor — **good earnings, excellent location. ROCHESTER:** Prestigious **Urology** practice. Fully equipped and furnished. Location growing in business, industry and beautiful residential areas. **Terms!! MT. PLEASANT:** Excellent **general practice** opportunity. Office-home combination. **$200,000 Gross Volume..great building..easy terms!! Call: Herbert Silverman, Associate Broker, Professional Practice Sales, Inc.,** 27208 Southfield, Lathrup Village, MI 48075 (313) 569-7336.

APPRAISALS AND EVALUATIONS. We specialize in determining the value of practices for any purpose — sale, purchase, buy-in, buy-out, financial planning, divorce, etc. We also specialize in partnership development and practice analysis. Protect your interests! Call Richard Corey, CMDC, Medical-Dental Management Consultants Corp., 31158 Perrys Crossing, Farmington Hills, MI 48331. Call Day (313) 661-0888 or Night (313) 661-0404.

PRACTICE FOR SALE: Excellent **family practice** and walk-in care facility. Desirable, modern, up-to-date, equipped office in the **Southfield-Lathrup Area.** Great visibility, signage and parking a plus. Must sell due to health reasons. Lots of growth potential. Call: Lainie, Day (313) 683-3733, Night (313) 661-0888.

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The Equitable	6
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Knoll Pharmaceuticals	37, 38
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Medical Automation	13
Medical Billing Service	2
Medical Newsletter	43
Medical Search Group	39
Mercy Health Services	38
Michigan Masonic Home	48
MPMLC	IFC, 29
Oakwood Hospital	53, 55
Palisades Pharmaceuticals	48
PC Medical	45
Pediatric Institute	47
Physician Service Group, Inc.	1
PICOM	51
Prescott, Ball & Turben	7
Roche	41, 42
Safe Stress	46
Shearson Lehman Bros.	52
St. Luke's	25
TransNational	28
US Air Force	44

OAKWOOD HOSPITAL FAMILY PRACTICE CLINICAL FACULTY POSITIONS

Oakwood Hospital, a 615 bed acute tertiary care university affiliated teaching institution, and the core hospital for an extensive 1,800 bed regional healthcare network, seeks to recruit two family practice physicians to join the faculty of our dynamic, fully accredited, independent, family practice residency program.

The family practice program, established in 1971, has a long history of quality resident teaching, is accredited to educate 18 residents, and provides care to over 15,000 patients per year. The faculty now consists of five residency trained, board certified family physicians, and a pediatrician, a psychiatrist, and a social worker. Our new family practice center opened in the summer of 1990 to provide for future growth.

The candidate for assistant program director will assume responsibilities that include:

- Clinical practice in our family practice center
- Clinical teaching of students and residents in an outpatient and inpatient setting
- Participation in the administration and the enhancement of the clinical and research curricula of the program

The candidate for associate program director will assume responsibilities that include:

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PRESIDENT'S PAGE

Physician-assisted suicide — A true dilemma

By Susan H. Adelman, MD

In an interview taped for Channel 4 (Detroit) on the Kevorkian case, as it so often happens, the reporter chose to show only a few minutes of a taped interview with me, to illustrate his prejudice that MSMS is reactionary and is totally opposed to assisting dying patients who wish to put an abrupt end to their suffering. He juxtaposed selections from my comments against those of an intensivist, who emphasized how cruel it is to let patients linger in intensive care units, and how important it is for medicine to face up to the need for these patients to die humanely and compassionately. MSMS was thus portrayed as tradition-bound and stodgy.

Unfortunately, all attempts to oversimplify the issues evoked by Doctor Kevorkian's action must fail. Medicine and all those who speak for it truly have a dilemma.

The profession is not ambivalent about the process of making choices for unconscious patients. We encourage each patient to have a living will or to designate a surrogate decision maker by executing a durable power of attorney. We also unanimously agree that there is no role for a physician in the death of a healthy, competent patient who wishes to commit suicide.

Our problems are limited to two categories of patients: 1) Patients who are suffering with a fatal disease, are perfectly capable of taking their own lives, but who wish to end their suffering more quickly and painlessly then they could alone, and 2) Patients who wish to put themselves out of their suffering, but who cannot do so unaided, because they are incapacitated.

Even most of the major world religions seem prepared to accept instances of withdrawing life support when the patient is clearly dying and after all attempts to heal and comfort have failed. The public and the health professions probably will eventually come to the consensus that anyone who is too incapacitated to commit suicide unassisted may be categorized as being kept alive by artificial means. This would mean that the act of discontinuing this support would be within the bounds of accepted medical and religious ethics. Legislation would then have to stipulate this exception to any prohibitions against assisting a suicide.

The big questions remaining are 1) Whether society is willing to permit anyone to legally assist anyone else to commit suicide, 2) Whether a physician can ethically, morally or legally assist the suicide of any patient, 3) Whether it is inhumane for a doctor to refuse assistance, if this assistance would make the difference between a painless death, and 4) Specifically, what the physician should do when faced with a competent patient on life support who insists on being allowed to die.

The central dilemma for the profession is the conflict between the physician's need to remain an advocate for life and the suffering patient's desire to find someone who is willing to help end a painful life in a humane fashion. If we abide by our Hippocratic Oath, the current AMA Code of Ethics, and the most restrictive of our religious tenets, and we deny the suffering patient assistance which will provide a painless death, are we being selfish?

Society has a conflict between the need to protect its members from any action which may really be homicide in disguise and the obligation to be sure that a healer who tries to compassionately relieve suffering with doses of sedative or analgesic medications is not sent to jail.

Society may eventually permit assistance with suicide, if the parties adequately document that they have followed an orderly process. The new guidelines of the Dutch Medical Association say that: 1) only a physician can implement the request for euthanasia, 2) requests must be made by competent patients, 3) patient's decisions must be free of doubt, well documented, and repeated, 4) the physician must consult another independent physician, 5) a determination must be made that no one pressured patients into their decisions, 6) the patient must be in unbearable pain and suffering without prospect of change, and 7) no measures can be available that could improve the patient's condition or render his or her suffering bearable.

The profession may eventually view the incapacitated patient who wishes to commit suicide as amenable to the same process. While requiring that the patient be given every possible chance to have a change of heart, the existence of a clearly accepted process would save the patient from the need to go through the lengthy legal process of obtaining a court order, and it would protect the assisting person from possible prosecution or lawsuit. This, for instance, was the position recently taken by a Nevada court, in the case of a quadriplegic, Kenneth Bergstedt.

Finally, we return to the most difficult of all the challenges thrown down by Doctor Kevorkian: whether it is not more humane to allow a patient to end life painlessly and quickly than to force a patient to starve to death from discontinuation of hydration and nutrition. Concern that active euthanasia may be forbidden by most of our own religions fills us with foreboding. Perhaps the next step should be a convocation of religious authorities, ethicists, physicians and jurists, to see if this murky area can be clarified, and if principles can be derived to cover most cases in the gray area. There will always be an irreducible minimum of cases that will have to go to court, but these should be very few, if the guiding principles are wisely drawn. Somehow these do not seem like the kinds of questions any of us can answer on our own. ■

Doctor Adelman is MSMS president.

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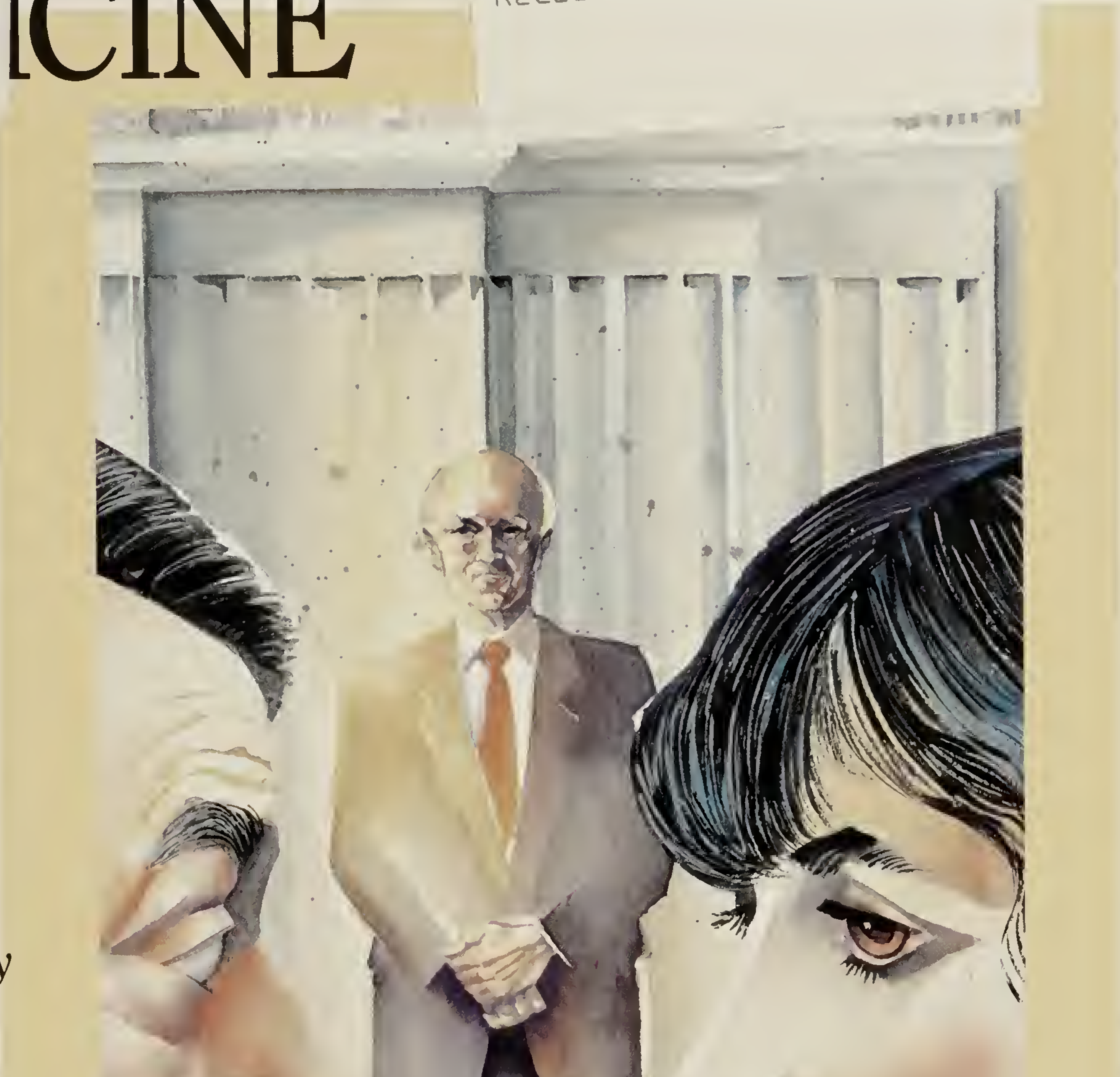

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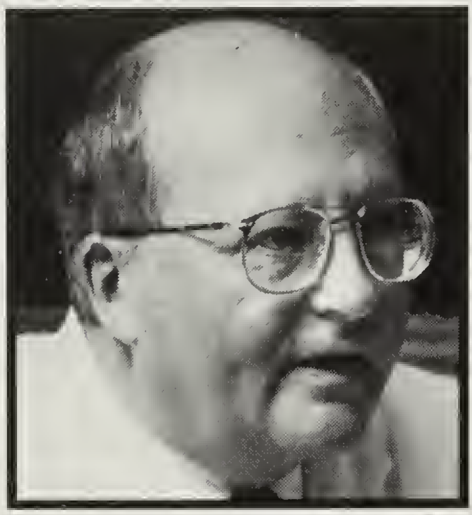

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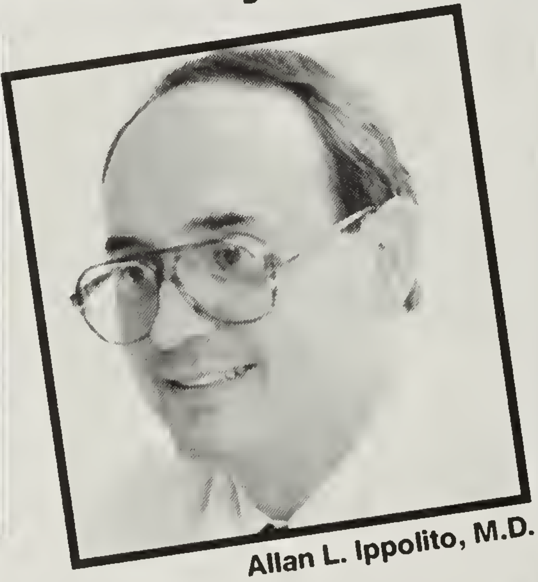

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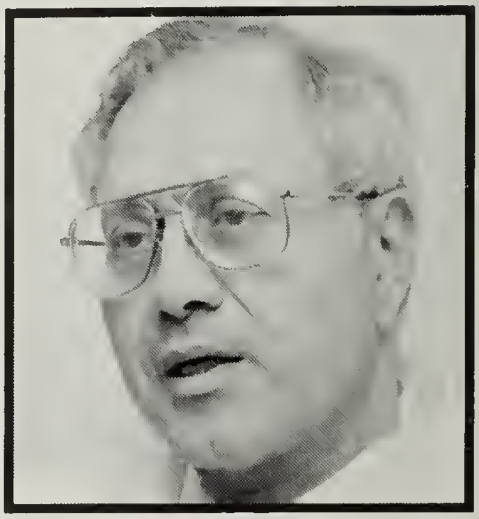

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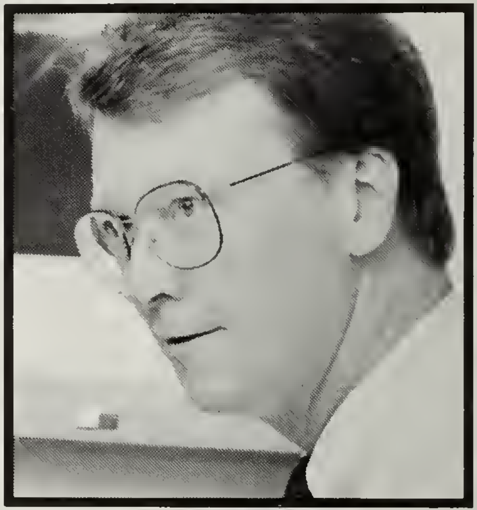

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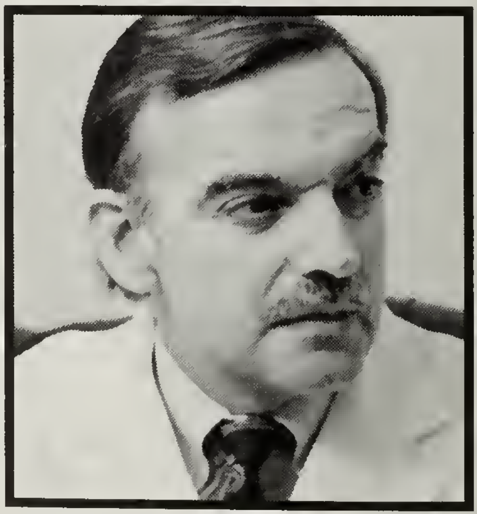

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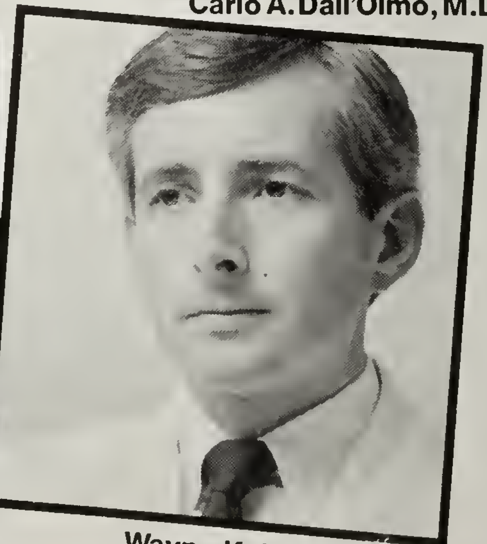

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MICHIGAN MEDICINE

29 **COVER STORY**
The Michigan Legislature recently authorized the use of a durable power of attorney for health care in Michigan. By creating a durable power of attorney for health care, one person can appoint another individual to make decisions concerning that person's care, custody, and medical treatment when that person is unable to participate in medical treatment decisions. How does it work? What is the physician's role? These are just a few of several questions addressed in this special 16-page pull-out section in this month's issue of Michigan Medicine. *Also included is an eight-page Patient Designation Form plus an order form for designation forms and patient brochures. This is certain to be a "must save" section.*

FEATURES

5 **REIMBURSEMENT ROUNDUP**
This is a new bimonthly feature prepared by the MSMS Department of Medical Economics and Health Care Delivery on reimbursement issues which affect physician practices.

15 **COUNTY MEDICAL SOCIETY SERIES**
This indepth profile of the Wayne County Medical Society marks the first in a series of articles on county medical societies in Michigan.
– BY MARLISE MICHAELS

23 **HEALTH EDUCATION FOUNDATION**
To encourage health care and healthy lifestyles is the aim of this foundation.
– BY CLAUDIA SKUTAR

27 **BOARD OF MEDICINE ACTIONS**

47 **SMALL AREA ANALYSIS**
This article shows that small area analysis — a population-based geographic method used to study variation in the rates of health care occurrences — can have significant impact on the improvement of patient care.
– BY JANE DEANE CLARK, PhD

DEPARTMENTS

7 **Letters**
9 **Newsfronts**
53 **New Members**
57 **Deaths**
59 **Meetings**
61 **Category I Courses**
65 **Classifieds**
71 **Advertising Index**
72 **President's Page**
"A Fond Farewell"
BY SUSAN H. ADELMAN, MD

Page 29

Page 15

In next month's issue of *Michigan Medicine*:
Professional liability.

Cover illustration by: *Robert L. Brent.*

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REIMBURSEMENT ROUNDUP

By Rose B. Heald
MSMS Reimbursement Ombudsman

This issue of *Michigan Medicine* introduces a new feature on third-party payor reimbursement issues affecting physician practices. The feature will appear every other month and is prepared by staff in the MSMS Department of Medical Economics and Health Care Delivery. Suggestions for topics that you would like to see discussed in the column should be forwarded to the Department.

Electronic Claims Processing Gains an Advantage

The Health Care Financing Administration is considering a change that may be a tremendous inducement for physician offices to convert to electronic claims processing, if they have not already done so: the agency, which administers the Medicare program, is looking at charging physicians one dollar per claim for all claims that are filed on paper.

A funding shortfall during the first days of 1991 forced HCFA to reduce funding levels for carriers and instructed them to allow paper claims to backlog while giving priority to timely processing of electronic media claims (EMC). Electronic claims are less expensive to process than paper, and there is every reason to expect that the Medicare program will continue to emphasize such cost savings measures.

In addition to HCFA's preference for claims filed electronically, physicians who make the switch can experience reduced claims rejections and faster turnaround on payment of claims.

Electronic claims processing allows you to move a claim form directly from your computer into the payer's computer, eliminating mail and input time at the payer's end, which can add at least a week to turnaround time. By filing claims electronically, you can also reduce the errors associated with manually re-entering data that may result in claims rejections and payment delays.

In addition, Medicare is proposing a new payment floor for EMC of 11 days compared to 17 days for hard copy claims.

EMC may also enable the physician's office to increase productivity by allowing you to transmit at the end of the day after the office has closed. This eliminates the need to compete with other offices in trying to link up to the carrier's computer.

Currently, 60 percent of Michigan's Medicare providers transmit electronically, which accounts for about 57 percent of all claims. BCBSM-Medicare anticipates a 2.6 percent increase in the number of electronically transmitted claims in 1991, a comparatively large increase over the .6 percent increase in 1990.

More detailed information on converting to electronic media claims processing will appear in future issues of *Michigan Medicine.*

Medicare Law Permits Cross-Coverage Billing But Not Locum Tenens

The Omnibus Budget Reconciliation Act of 1990 paved the way for all Medicare carriers to reimburse for cross-coverage; however, it did not change the prohibition of locum tenens situations.

The recent changes allow reciprocal arrangements between physicians in separate practices. The doctor who is away can bill for services the fill-in doctor actually provided while the primary doctor was away on a weekend or on vacation. The operative word is "reciprocal." However, the claim must list the fill-in doctor's UPIN, and the arrangement cannot span more than 60 days.

Current Medicare law as revised by OBRA 90 prohibits reimbursing the primary doctor who bills for services that the *locum tenens* doctor actually provided. The difference here is that the coverage/billing arrangement isn't reciprocal.

The Health Care Financing Administration is hoping that Congress will change the law to allow *locum tenens* arrangements. *Locum tenens* arrangements were allowed by the Michigan Medicare carrier prior to OBRA 90, but if Congress does not change the law HCFA may instruct all carriers to discontinue reimbursement for such situations.

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Letters from Our Readers

Resources available on effects of hazardous substances

Your July 1990 cover story entitled "Environmental Health — Physicians Must get Involved" was recently called to my attention. As assistant surgeon general and assistant administrator of the Agency for Toxic Substances and Disease Registry, I would like to describe some of the resources available to aid physicians in learning about the human health effects of exposure to hazardous substances.

Toxicological Profiles. These documents describe environmental, chemical, medical, and public health aspects of the hazardous substances found at National Priorities List (NPL, or "Superfund") sites. Each document opens with a public health statement, targeted to the layperson, that briefly summarizes the health aspects of the substance. Final versions of the profiles are available through the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161, 1-(800) 336-4700 or (703) 487-4650.

Case Studies in Environmental Medicine. This monograph series is designed to guide physicians through the diagnosis and treatment of illness related to hazardous substance exposure. Each case study is written for a specific chemical on the NPL list. Continuing medical education credits are available.

Newsletter. Health care professionals have a forum for exchanging information about environmental health in *Hazardous Substances and Public Health.* Subscriptions are free to primary care providers and other health professionals.

Cooperative Agreements. ATSDR offers funding and assistance to 20 state health departments for developing educational materials and activities in environmental medicine for health care professionals. Through an agreement with the National Association of County Health Officers (NACHO), a series of short courses in environmental health are presented at national and regional meetings for local health officials, physicians, and other public health professionals.

Another cooperative agreement, with the Association of Occupational and Environmental Clinics (AOEC), focuses on educating primary care professionals. The association plays a key role in medical care, surveillance, and health and medical education, influencing the development of environmental health programs in medical school curricula.

Databases. ATSDR assists in establishing and maintaining the toxicological databases of the National Library of Medicine (NLM). TOXNET, the primary network developed by NLM's Toxicology Information Program, includes the Hazardous Substances Data Bank (HSDB), the Registry of Toxic Effects of Chemical Substances (RTECS), and other useful files.

Emergency Response. ATSDR provides health-related support in public health emergencies involving hazardous substances. A 24-hour emergency response number (404) 639-0615 offers expert consultation in emergency response coordination, toxicology, chemistry, medicine, and environmental health and, if necessary, response to the scene.

For more information, contact Donna Orti, ATSDR, E33, 1600 Clifton Road, N.E., Atlanta, GA 30333; telephone (404) 639-0700.

Barry L. Johnson, PhD
Assistant Surgeon General
Department Public Health
Atlanta, GA

Encounter with inquisitive social worker strikes a familiar chord

The following is a letter sent to MSMS President Susan H. Adelman, MD, regarding her President's Page which appeared in the February 1991 issue of Michigan Medicine.

Your article in *Michigan Medicine* of February 1991 relating your encounter with the inquisitive social worker strikes a familiar chord. The suggested solution to the problem – more legislation – is likely to create more hassle and confusion. What we need is psychotherapy for ourselves. We have a big attitude problem. We have been beaten into the mold of a spouse abuse victim. We seem to accept the premise: every doctor is a crook until he proves otherwise. We are all too happy to cooperate with every Dick, Joe, or Henrietta questioning our conduct.

I have learned to say no to phone solicitors. I am learning to say no to impertinent queries, even as they come from fellow physicians operating under the tired cliche of "quality control."

I hope MSMS will develop an affirmative action program designed not by legislators but by our able and dynamic MSMS leadership. Let's try to salvage what is left of our osteolytic backbone!

Gustav A. Uhlich, MD
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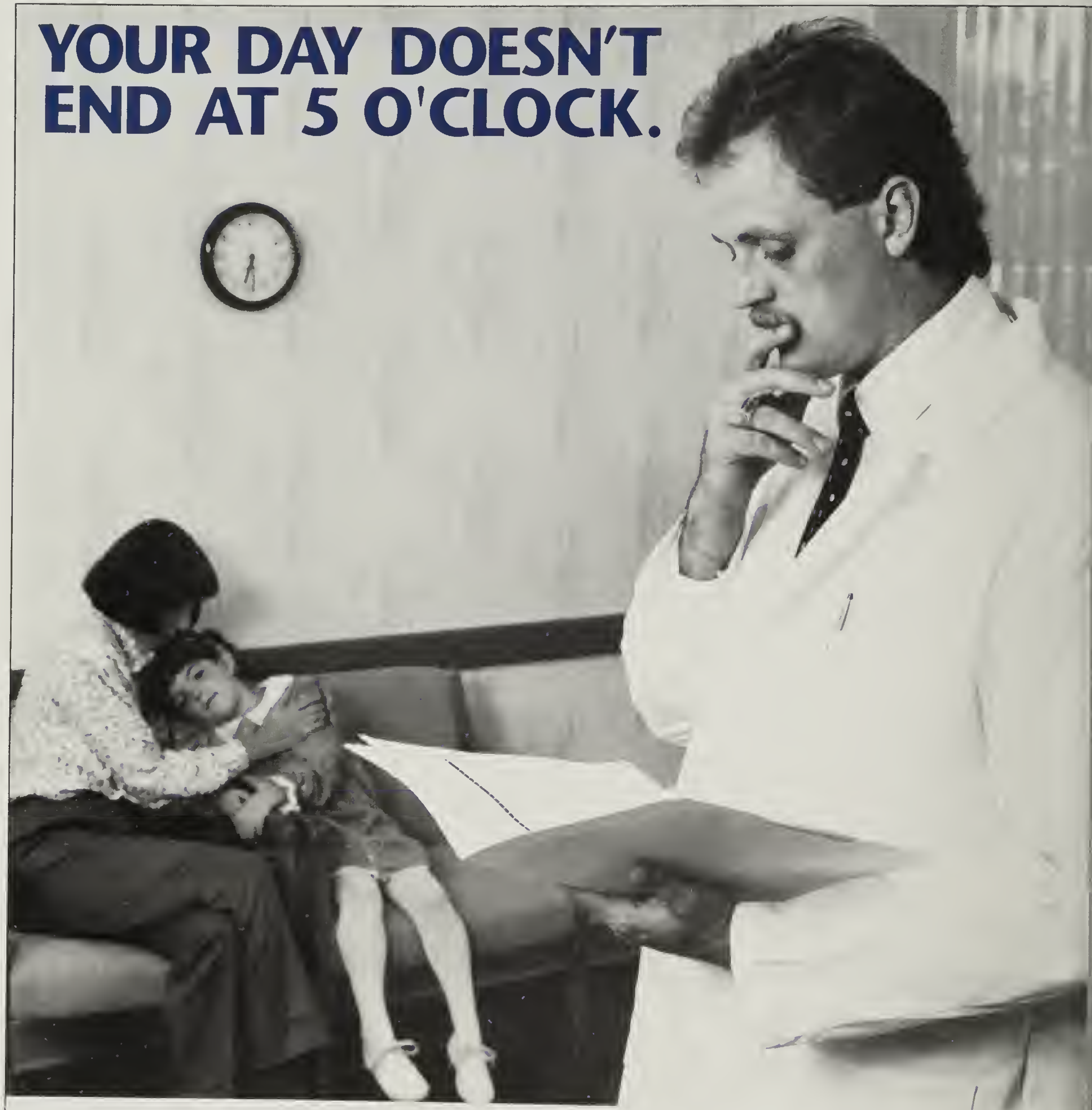

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MEDICAL NEWSFRONTS

INDEX

Henry Ford offers promising new treatment for stroke 9

Sinai offers new hope for back pain sufferers 9

WSU/CAAD receives grant to increase AIDS services 9

Support network links transplant patients 10

Oakwood first to offer new treatment for chronic spasms 10

U-M licenses rights to new flu vaccine to Wyeth-Ayerst 10

Ann Arbor hospital named heart bypass center 10

Inpatient hospice opens at Saint John Hospital-Macomb 11

Sinai has new laser for stone disease treatment 11

Beaumont seeks volunteers for diet, exercise study 11

U-M professors author new book on international need for physicians 11

More epinephrine needed for effectiveness Henry Ford reports 12

Henry Ford offers promising new treatment for stroke

Henry Ford Hospital and Health Sciences Center is one of nine medical centers in the country where a promising experimental treatment for truly acute stroke is now available. As part of a three-year, nationwide study funded by the National Institutes of Health, researchers will determine whether the clot-dissolving drug TPA can effectively reduce the ravages of stroke compared to conventional therapy.

"We hope TPA will prove to be the first treatment ever for significantly altering the course of truly acute stroke and minimizing the number and severity of disabilities suffered by these patients," said Steven R. Levine, MD, of the Center for Stroke Research and Department of Neurology, who is director of the clinical stroke service and acute stroke unit and is serving as principal investigator of Detroit's clinical center.

To be eligible to enroll in the study, patients should arrive at Henry Ford Hospital's emergency room as soon as possible after the onset of stroke. Study participants will be divided into two groups; those who receive treatment within 90 minutes and those who are treated 90 minutes to three hours after symptoms first appear. The study is a double-blind, placebo-controlled trial.

Henry Ford Hospital also is serving as the coordinating center for the study. This represents the first time the institution has been selected as the coordinating center on a nationally funded research contract. The coordinating center was funded for $1.1 million. The clinical center received a contract for $728,000. Both programs will run for three years.

The study will include 280 stroke patients at nine medical centers around the country. In addition to Henry Ford Hospital and Health Sciences Center, centers in the study are: the University of California, San Diego; the University of Cincinnati; Emory University, Atlanta; the Long Island Jewish Medical Center; the University of Maryland, Baltimore; the Semmes-Murphy Clinic, Memphis; the University of Texas Health Sciences Center, Houston; and the University of Virginia, Charlottesville.

For more information about the study, call the Henry Ford Health System Strokeline at (313) 876-8090.

Sinai offers new hope for back pain sufferers

Sinai Hospital has acquired a new computer-assisted device to help evaluate and rehabilitate low back injuries. The device, called the IsoStation B-200, was developed by Isotechnologies, Inc. of Hillsborough, NC.

"Nationally, back injuries are industry's number one health problem," said Joseph Honet, MD, chairman of the Department of Rehabilitation Medicine at the Detroit-based hospital. "Annually, back problems cost more than $40 billion for treatment and worker's compensation.

"With the IsoStation B-200, we have the finest technology available today to help evaluate and treat low back problems."

The B-200 measures motion as a patient moves naturally, noting forward and backward side to side and rotation movements. Exertion, speed and angle in each movement are recorded. Information about the patient's movement is recorded by a computer where it can be analyzed graphically. A health care professional can use the information to help pinpoint the pain, evaluate the problem and prescribe a rehabilitation program.

In addition to treating patients, the B-200 is widely used for pre-employment screening. It can also be used for post-operative testing and rehabilitation, to determine when an employee is ready to return to work.

WSU/CAAD receives grant to increase AIDS services

The Comprehensive AIDS Alliance of Detroit (CAAD) has been awarded a three-year grant by the Department of Health and Human Services to provide a continuum of medical and social services for persons in the Detroit area with AIDS and those infected with the HIV virus.

Under the direction of Lawrence Crane, MD, associate professor of medicine at Wayne State University and section chief of infectious diseases at Harper-Grace Hospital, the funding will be used for three specific purposes. The CAAD will expand its primary care services for Detroit's HIV-infected minorities, indigents, and drug users with the creation of a dedicated, full-time primary care clinic. Currently, the CAAD shares its outpatient clinic area and its personnel with several other medical clinics and is limited to six half-day clinics per week.

The CAAD will establish an on-site patient and family

Continued on page 10

Continued from previous page

health education center to include increased testing, counseling and partner notification services. At present, there is no single resource in the city for health education of persons with AIDS and their families. The proposed center would include informative multimedia materials on HIV infection and its transmission, recognition of symptoms and signs of opportunistic infections and malignancies, and therapy. A nutritionist and health educator will be employed to provide on site patient/family education.

The final goal is to develop an on-site evaluation and referral system for persons engaged in substance abuse, operated by physicians skilled in addiction treatments. As part of this same goal, the CAAD would also like to develop a mental health clinic on site to operate one-half day a week for referred HIV-infected patients.

Support network links transplant patients

The Children's Leukemia Foundation of Michigan (CLF) announces the immediate availability of a Bone Marrow Transplant Partner Network for individuals facing the possibility of a bone marrow transplant as treatment for leukemia, lymphoma or other related blood disorders.

The network is open to patients throughout Michigan who wish to learn about BMT transplantation from someone who has already undergone the procedure. The network is intended to offer support based on the sharing of personal experience by BMT patients and/or family members of patients.

Individuals interested in the Bone Marrow Transplantation Partner Network may call the Children's Leukemia Foundation of Michigan at (800) 825-2536. Because of the highly personalized nature of this service, it may take two to three weeks to process requests. The feelings and opinions expressed will be based on the individual's own experience, and while emotionally supportive, comments will not include medical advice.

Oakwood first to offer new treatment for chronic spasms

Oakwood Hospital, Dearborn, is the first hospital in Michigan to offer an investigational procedure to control spasms of patients with multiple sclerosis or spinal cord injury.

This procedure involves installing a small pump in the patient's abdomen. The pump transports a programmed dose of the spasm-controlling drug, Lioresal (Baclofen), directly to the spinal cord area to relieve the spasms.

The SynchroMed Infusion System consists of a drug pump, catheter, and programmer. The pump, with its drug reservoir containing Baclofen, is implanted under the skin in the patient's abdomen or chest. Once implanted, it can be externally programmed via radio signals to dispense a drug to a specific site in the body with precise timing and accuracy.

Arek L. Sarkissian, MD, vice chief of Oakwood Hospital Medical Staff and a neurosurgeon, performed the first procedure at Oakwood in December 1990.

"We are very pleased with the results of the first procedure," Doctor Sarkissian said. "The patient's spasms have been relieved, she's doing very well, and is undergoing physical therapy to regain some muscle strength and tone."

The new procedure has widespread applications and can dramatically improve the quality of life for patients.

"Patients with severe spasticity simply cannot function," Doctor Sarkissian said. "Even simple touch can be painful to them and set off spasms. The distribution of Baclofen through the pump allows them to perform simple tasks and enter rehabilitation therapy to improve their quality of life."

Baclofen has been used for the control of spasms for many years, said Doctor Sarkissian. "This is just a new way of using it."

Neurologists evaluate all candidates and determine their eligibility for the procedure.

Patients must meet certain criteria to be a candidate for the pump insertion. The patient must have a diagnosis of severe chronic spasticity due to spinal cord injury and be unresponsive to oral Baclofen or have unacceptable side effects from the pill form. In addition, the patient must undergo a spinal tap injection of Baclofen.

The Food and Drug Administration (FDA) under special investigational protocol, has approved the use of the Medtronic SynchroMed Implantable Programmable Infusion System by Oakwood Hospital.

U-M licenses rights to new flu vaccine to Wyeth-Ayerst

The University of Michigan has licensed worldwide rights (excluding Japan) to its "cold-adapted influenza virus vaccine" (CAIV) to Wyeth-Ayerst Laboratories.

The vaccine was developed over the past 30 years by Hunein F. Maassab, U-M professor of epidemiology; researchers at the National Institute of Allergy and Infectious Diseases; and collaborators across the country, including scientists at the Centers for Disease Control and the US Food and Drug Administration.

Unlike conventional influenza vaccines, the cold-adapted virus is a modified living virus that is administered by nose drops rather than injection. The vaccine, which combines the core of a harmless flu virus with the covering from a virulent strain, triggers a stronger, longer-lasting immune reaction than does the conventional dead-virus vaccine.

"The CAIV vaccine, which has been tested in more than 5,000 subjects, has an excellent safety profile and is particularly effective in children," Doctor Maassab says. "Children, and some adults, also prefer the nose-drop administration to an injection...an advantage that should result in widespread usage."

According to Doctor Maassaab, an added bonus to the vaccine is its adaptability. "The harmless virus that composes the core of the vaccine can be stored until a flu epidemic breaks out, and then retrofitted with an outer covering that matches the virus causing the epidemic."

Ann Arbor hospital named heart bypass center

St. Joseph Mercy Hospital, Ann Arbor, has been chosen by the federal government as one of four US hospitals designated as a "Medicare Participating Heart Bypass Center." Government experts reviewed extensive program data from over 200 applicants before selecting there hospitals.

The four hospitals will participate in a demonstration project developed by the Health Care Financing Administration (HCFA). The project specifically assesses the potential benefits of "package pricing," a reimbursement method which combines the fees of both physicians and hospitals.

The goal of the project is to increase the quality of health care services provided to medicare patients while reducing the cost and complexity associated with billing and reimbursement. This is a landmark effort by HCFA to respond to the national concerns regarding the cost of health care and the quality of the care provided.

Finalists were chosen on the basis of the quality of their program, their agreement to provide services at a negotiated rate and their ability to manage and coordinate the complex services needed for high-quality care.

In 1990, 750 open heart procedures were performed at St. Joseph Mercy Hospital, making it one of the highest volume cardiac surgery centers in Michigan.

Physicians and hospital officials expect to attract patients from throughout Michigan and the Great Lakes Region. While Medicare patients may chose to go to one of the four participating hospitals, they are under no obligation to do so. All other hospitals will continue to provide services and receive payments under the traditional Medicare program.

The bypass surgery demonstration at St. Joseph Mercy Hospital will begin in early 1991 and will continue for three years. During the entire course of the demonstration project, the hospital and HCFA will closely monitor the quality of patient care, the success of the process in returning patients to their normal lifestyles and the achievement of the objective of lower cost.

Inpatient hospice opens at Saint John Hospital-Macomb

The first and only inpatient hospice service in Macomb County has opened at St. John Hospital-Macomb Center (SJH-MC) in Mt. Clemens. SJH-MC has contracted with the Michigan Cancer Foundation and the Hospice of Southeastern Michigan establishing an inpatient hospice service for patients in the final stages of cancer and other terminal illnesses.

John Burrows, MD, section chief of oncology at St. John Hospital and Medical Center, Detroit and medical director of the new hospice service, will work closely with St. John oncologists, referring physicians, Social Work Services, Homecare and oncology nursing staff to establish the service.

"The hospice program will add a new level of care to our oncology services by allowing patients to die with dignity and respect in a private, serene setting," says Doctor Burrows.

According to David Sessions, administrator, SJH-MC, "Staff privileges will be offered to St. John Hospital and Medical Center oncologists so that they may follow their patients through the Hospice program."

Mina Frank, associate administrator for SJH-MC and the hospice service, recommends that physicians refer to either the Michigan Cancer Foundation or the Hospice of Southeastern Michigan early in the patient's diagnosis, as home care needs are determined and provided by these two organizations.

"Ninety-five percent of care given to terminally ill patients is done at home," she says. "Our primary focus for the hospice will be to provide the highest level of comfort for the patient and family during the final stage of illness."

For more information, call (313) 465-5501.

Sinai has new laser for stone disease treatment

Patients suffering from painful kidney stones and gallstones may be treated at Sinai Hospital, Detroit, with a new pulsed dye laser. Sinai physicians using the new Candela pulsed dye laser, the MDL 2000 LaserTripter, utilizes a video camera for guidance through the surgical procedure. By watching a video screen, the stones are identified, and the laser is activated, fracturing and dissolving the stones.

An Oak Park woman became Sinai's first patient treated with the new laser. For a month, she had suffered painful attacks caused by a ureteral stone. Sinai urologist William Rattner, MD, used the LaserTripter to destroy the stones. The outpatient procedure took only 30 minutes to complete.

According to Doctor Rattner, the procedure was a complete success and the patient returned to work 36 hours later.

Sinai Hospital Laser Surgery and Photobiology Institute Manager Larry Elson says the new laser may be used to treat kidney stones and gallstones. Research with the new laser includes possible peripheral vascular and oral surgery applications.

Beaumont seeks volunteers for diet, exercise study

William Beaumont Hospital's Department of Cardiac Rehabilitation is seeking male volunteers, ages 25-45, who currently are inactive and are 20 to 50 pounds overweight, for a diet and exercise research study.

The purpose of the research study is to determine if a walking program, of mild or moderate intensity, may help prevent the decrease in metabolism that normally occurs with calorie reduction.

Volunteers will receive free cholesterol, body fat and oxygen consumption evaluations and will undergo exercise stress testing before and after the research study. They will receive individual dietary instructions, based on their metabolic rate and ideal body weight, and will be closely monitored using a diet diary.

Study volunteers must also take part in a walking exercise program held four times a week for an eight-week period at Beaumont's Rehabilitation and Health Center in Birmingham.

For more information, or to volunteer for the research study, call Marsha Damon or Beverly Collins in Cardiac Rehabilitation at (313) 258-3705.

U-M professors author new book on international need for physicians

The crucial health care issues of how many doctors a country needs, what their medical specialties should be, and how their skills can be distributed equitably among the country's population are examined in depth in a newly released book, *The Political Dynamics of Physician Manpower Policy*, published by Elsevier Science Publishers (Amsterdam, Oxford, New York).

Editors of the book are: Marilynn Rosenthal, PhD, professor of sociology and director of the Health Policy Studies program at the University of Michigan-Dearborn; Irene Butter, PhD, professor of public health policy, the University of Michigan-Ann Arbor; and Mark Field, PhD, professor emeritus of sociology, Boston University, and fellow, Harvard University Russian Research Center.

The Political Dynamics of Physician Manpower Policy consists of a series of papers which were presented at a conference of the same name in London, England, in May 1988. This invitational conference, attended by 25 experts from 12 different countries, was funded by the American Kaiser Family Foundation and the English King Edward Fund. The

Continued on page 12

Continued from page 11

physician manpower policies of eight countries...Germany, Israel, Mexico, the Netherlands, Spain, Sweden, the United Kingdom, and the United States...are presented in the book, as well as context, discussion and summary chapters.

Among the central findings of the book are that no country appears to be successful in implementing a national physician manpower plan. External factors such as national budget concerns, immigration policy, ethnic minority concerns and democratizing opportunities for advanced education consistently supersede a nation's physician manpower plan and policy. As a result, most countries are currently experiencing a concurrent shortage and surplus – a "shortplus." – of physicians; more doctors than are needed, but shortages in certain specialties and geographic areas.

Further information on *The Political Dynamics of Physician Manpower Policy* is available by contacting editor Rosenthal through the UM-Dearborn Health Policy Studies program, (313) 593-5287.

More epinephrine needed for effectiveness, Henry Ford reports

The standard procedure for resuscitating patients whose hearts have stopped may fall far short of what is necessary to save the most lives, a new study from Department of Emergency Medicine at Henry Ford Hospital suggests.

The standard dosage of epinephrine needs to be 10 to 20 times larger in order to be more effective, according to the study.

"The bottom line is that the recommended dosage of epinephrine does not give the heart its best chance of restarting during cardiac arrest," says Gerard Martin, MD, director of research for the Department of Emergency Medicine, Henry Ford Hospital and one of the principal authors of the study. "It isn't that the smaller dosages don't help. It's just that they're not nearly as effective as larger dosages appear to be."

In this study, researchers administered high-dose epinephrine to 32 patients who had suffered cardiac arrest. In all of these patients, the standard therapy for resuscitation had already been tried and had failed. Researchers discovered that a dosage 14 times higher than the standard one milligram increased blood pressure in these subjects by at least threefold, significantly increasing the odds that the heart would resume beating normally.

In fact, the larger doses were so effective at restarting hearts that researchers actually resuscitated several patients who were considered well beyond hope.

"Our purpose was not to restart these patients' hearts. Because we didn't start working with them until after they had been declared hopeless, we didn't expect that to happen," said Doctor Martin. "But to our immense surprise, in three out of the first five patients who received high-dose epinephrine, their hearts did restart."

Unfortunately, none of the patients in this study survived for any length of time.

However, Mark Goetting, MD, acting division head, Pediatric Critical Care Medicine, Henry Ford Hospital, and also one of the authors of the study, has started using high-dose epinephrine to treat patients before they reach the point of no return with significant success. ■

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WAYNE

Wayne County Medical Society's William Beaumont Room, the site of numerous meetings, is housed at Society headquarters.

Large, Active Membership Key to Success of Wayne County Medical Society

By Marlise A. Michael and WCMS staff

Editor's note: This is the first in a series of profiles on county medical societies in Michigan.

At any given moment, you can walk into the Wayne County Medical Society (WCMS) Headquarters and see the phones lit up with incoming calls, hear typewriters tapping out letters of application acceptance and see a flurry of activity from the kitchen as the staff prepares lunch for the committee or specialty society meetings taking place in one or all three of the conference rooms. With three officers, 27 committees, a full-time staff and a very active membership of more than 4,000, WCMS is almost always bustling with activity, but that is to be expected of Michigan's oldest and largest county medical society.

A rich history

Although WCMS changes with the times, the Society has a rich and reputable history. The formation of Michigan Medical Society in Detroit on August 10, 1819, and the Territorial Medical Society on January 11, 1820, are considered to be the beginnings of both WCMS and the Michigan State Medical Society (MSMS).

The first local society was formed in 1846 with the organization of "The Sydenham Society," under the direction of Charles N. Ege, MD, but after a few years, this society was disbanded. On April 14, 1849, the first "Wayne County Medical Society" was formed. In 1851, the laws under which it existed were repealed and it was reformed in May, 1853, as the Detroit Medical Society, whose first president was Morse Steward, MD. This society had an active career for about five years until it was disbanded in March, 1858.

For a brief time after that, there was no local medical society in the county until May 31, 1866, when the second Wayne County Medical Society was formed, its first president being Zina Pitcher, MD. Meetings were held quarterly until early in 1876 when it adjourned. On August 21, 1876, the third Wayne County Medical Society, as we know it today, was constituted and organized under the presidency of William Brodie, MD, and incorporated under the laws of the State of Michigan.

"Because we have been in existence since 1876 and we are so large, we have a good reputation and wield a little power," said Kathleen Maslanka, WCMS executive director. "Essentially, the Society and organized medicine as a whole, exist to give physicians a voice in the decisions affecting their profession. We run on a committee structure and any physician who becomes active on the committee level or runs for office has the opportunity to influence the state of health care. Because of our size, we can make a real difference in health care on a local, state and national level. If someone has a problem, it does not have to be fought alone. I marvel at how our members join forces with one another."

WCMS is like a large family, according to the Society's 1990-1991 President Krishna K. Sawhney, MD. "We have various minorities, ethnic groups, specialists, men and women alike," Doctor Sawhney said.

"When their thoughts are combined, we can come up with ideas to create superb programs and solve complex problems. We obtain the perspective from the full-time teaching faculty and those in private practice. We are blessed with employed physicians as well as those who do research, and due to all of this diversity, resolutions brought by Wayne County have shaped the future of medicine in Michigan for many years. Our power is in our diversity and our history."

Recognizing the value of the programs instituted in the early days, WCMS continues to build on these celebrated activities, such as the William Beaumont Lecture.

Established in 1922 the lectureship series was funded with $9,000 remaining from the Patriotic Fund set up during World War I. The essayists were to be of the highest rank, outstanding teachers and investigators, dealing with subjects of value to all physicians. An honorarium of $300 was established.

WCMS often holds press conferences at its headquarters, such as this one led by WCMS President Krishna Sawhney, MD, (at podium).

The first Beaumont Lecture was deliv-

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WCMS sponsors the Annual Beaumont Lecture, like this one held at Harper Hospital, Detroit.

Continued from previous page

ered by W.G. MacCallum, MD, of Johns Hopkins University, who spoke on "Inflammation," before an audience of 500 physicians and guests.

After 70 years of uninterrupted programs, this year's annual Beaumont Lecture will be delivered April 8 at Sinai Hospital by John Rebuck, MD, PhD, of Henry Ford Hospital, who will speak on "Another Michigan Window-Human Skin Window."

In addition to the annual Beaumont Lecture, WCMS also conducts numerous programs throughout the year. Recent programs have included a stress management group for members going through a malpractice liability suit, a public information campaign on the liability problem which included radio spots, and numerous educational and general membership programs.

Large size a plus

Being the state's largest county medical society, WCMS has advantages that smaller societies do not have, such as a full staff, a weekly newsletter, numerous committees, a 34-member council that meets regularly, and a very unique 124-member delegate body that represents most hospitals and geographic regions in Wayne County.

Because the Society is so diverse, it also has had the opportunity to develop two foundations — the Else Kolhede Foundation and the Metropolitan Detroit Foundation for Health Education (MDFHE). The Else Kolhede Foundation is made possible by donations received for polio vaccines in the 1960s. Named after Else Kolhede, who served as executive secretary for 10 years, the foundation provides grants for such projects as the recent purchase of cancer research equipment by Harper Hospital.

The two-year old Metropolitan Detroit Foundation for Health Education is a community foundation and has received grant funding for several projects, including two 15-minute educational videotapes. It also is the fiduciary agent for Project HOW (Health on Wheels), which provides free health care to the county's medically indigent population at five different church site clinics.

WCMS President Krishna Sawhney, MD, (right), presents Carl Gagliardi, MD, with a special resolution recognizing his years of dedication to organized medicine at a 1990 Delegate Body meeting.

Having the opportunity to take advantage of such variety is one of the benefits of being a part of such an influential county society, according to Maslanka, who was named executive director in March 1990. As the executive director of such a large and active membership, Maslanka views her role as that of a catalyst. "Members of this society are involved in every (medically-related) group in our community," she said. "It is my job to be the facilitator — receiving information from many avenues and passing it on in the best way possible. I act as the treasurer for some groups, editor for others and manager for all. I really enjoy the challenge and variety."

Because of its varied proportions, WCMS also has its own building equipped with a 200-seat dining room, full kitchen, and a 400-seat auditorium which is frequently rented to Wayne State University and other specialty organizations. "Owning our own building has its pluses," Maslanka said, "but trying to keep up with the tenants, repairs and the costs is difficult and something with which our Board of Trustees frequently grapples."

WCMS has had several headquarters. Its first location was on East High Street in 1910. Its next home was the Maccabees Building on Woodward Avenue. (1927-1932). Here, the Women's Auxiliary was organized and the multiple activities of the Society were achieving national recognition and praise, according to William Reveno, MD, who at 93, has been a distinguished member of WCMS since 1922.

"Everything was coming up roses," Doctor Reveno said. "But then came 1929 with the economic clouds darkening, predicting the approaching storm. Gradually the cash flow dried up. Members could not pay their dues and the Society was no longer able to meet expenses. Doctors moved out of their elaborate offices in the building into smaller quarters elsewhere or they combined into varied-sized groups with reduced overhead. By 1932, the Society, unable to arrange a reduction in rent, decided to move."

The David Whitney family estate offered occupancy in their elaborate former home on Woodward and Canfield, which became the Society's third home (1932-1958), now The Whitney restaurant. In May of 1958, WCMS moved to the second David Whitney House, its present location, so it could be next door to the medical school. Since then, the medical school moved to the Detroit Medical Center and the Wayne State University (WSU) Pharmacy and Allied Health Building are the new tenants.

"Having a building is a great way to offer an image, Maslanka said. "However, we sometimes forget that our member are doing their work within the community. We need to go to them and connect with them on their own turf. One of the things we have learned this year is that we must leave the building and see our members working within the community."

This lesson has come from a pilot program of the WCMS Membership Committee chaired by Gilbert Bluhm, MD. Committee members and staff are going back to the hospitals to discuss the positive points of organized medicine at scheduled medical staff meetings. Meetings with the hospital chiefs of staff also have helped in the membership arena.

More than 130 professionals listened to a variety of local and national experts at a conference on "Medical, Legal and Ethical Responsibilities Toward the Terminally Ill," held at WCMS headquarters last October.

Many outside ties

Because of its location, WCMS has the opportunity to work with several of Detroit's organizations and hospitals, such as the Greater Detroit Area Health Council, the Detroit Medical Center, Southeast Michigan Health Council, Henry Ford Hospital and both the Wayne County and Detroit departments of public health. "Our ties with groups such as Blue Cross help us to get member questions answered quickly as well as working together when real crises occur," Maslanka said.

The Detroit Medical Society (DMS) is another organization with which WCMS joins forces. "The Detroit Medical Society has always tried to work harmoniously with its sister medical societies in the Detroit area," said James Johnson, MD, vice president of DMS medical affairs. "This has been evidenced by the very successful Project HOW (Health on Wheels), which is a co-sponsored effort by the Detroit Medical Society and the Wayne County Medical Society."

Another highly successful united event was the Drug Education Awareness Program in the Detroit Elementary Schools, spearheaded by then Supreme Court Justice Dennis Archer. The medical portion of this event was a co-sponsored project of MSMS, the Detroit Black Nurses Association and the Wolverine Dental Society, WCMS and the DMS.

Founded in 1895, the DMS is an organization composed of most of the African American physicians in the Detroit area and is a component society of the National Medical Association. Throughout its history, the DMS has been concerned about the health and welfare of the Detroit community. The very successful Fight for Freedom Dinner, sponsored by the National Association for the Advancement of Colored People (NAACP), was instituted in 1955 by the DMS.

Integration of the Detroit Medical Center was spearheaded by the DMS. The first African American physicians granted admitting privileges to a medical center hospital in 1959 were members of the DMS.

In addition to organizations like the DMS, WCMS also has developed a working relationship with local media. With its own public relations staff, community and public relations play a big part in creating an image for the Society. It is not unusual to see the current president on the television news presenting the Society's views on a particular medical issue.

WCMS also works closely with the WSU School of Medicine — a very important part of WCMS. Its faculty makes up a substantial portion of physicians in Wayne County and many are members of WCMS, according to Robert Sokol, MD, WSU School of Medicine dean and WCMS member.

"The close relationship between the School of Medicine and WCMS is like General Motors, only instead of Cadillacs, we produce physicians, some of them being future members of the Society," Doctor Sokol said. "In fact, over 40 percent of all physicians practicing in the Greater Detroit area received all or part of their training in WSU-affiliated programs and many of our faculty are members of the Society."

Any medical school has a combination of missions, according to Doctor Sokol. "First and most obvious is education," Doctor Sokol said. "The second mission is to produce new knowledge and major research. The third, which is most frequently missed, is service. Part of our mission is taking care of patients, and that is clearly where the WSU and WCMS agendas overlap. We have similar concerns, such as liability insurance, which highly affects our faculty. The Hutzel case is a good example. A case like that could put a major OB/GYN service out of business and WCMS has certainly spoken out about that. WCMS helps us speak to patient care issues, particularly for the medically indigent, which is part of the mission of the school of medicine."

Close ties with MSMS

In addition to the medical school, WCMS also works closely with MSMS. Of the 11,000 MSMS members, Wayne County physicians comprise one third of that total. One example of how both societies work closely together is through their publications. "Our newsletter, the *Detroit Medical News*, is the only county weekly publication in the country," Maslanka said, "and it has a wide distribution, so the state can look to us to promote their programs and we do the same. We must remember we are all on the same team."

"But in other areas, we find ourselves trying not to compete with the state, such as offering the same services in our service bureaus," Maslanka said.

In 1978, WCMS established the WCMS Service Bureau Inc., a wholly-owned subsidiary corporation. It offers several business services to WCMS members such as group insurance programs, discount office supply purchasing, a telephone answering

WCMS President Krishna Sawhney, MD, (standing), discusses the initiation of two new task forces — the Leadership Development Task Force and the Task Force on Physician Retention — at a recent WCMS Council meeting.

Continued on next page

Wayne County Medical Society Headquarters.

Continued from previous page

service, a beeper/paging service and is currently considering the addition of a waste disposal program.

"In some ways, the overlap is healthy because we consider MSMS as the parent organization, but we have more of a parent/adult-child relationship which often can put us on an equal footing with the state."

Communication a key mission

Although providing the best possible health care to the public is one of WCMS's primary functions, communicating with physicians about quality health care is the Society's principal mission, according to Frank B. Walker, MD, who was WCMS president in 1984-1985.

"I got my first committee assignment on the WCMS Ethics Committee and it was fascinating," Doctor Walker said. "It was a way to get out and meet physicians from different specialties and physicians with our own interests.

"From the representative standpoint, it is advantageous to be a part of a large society because the more people that are members, the more delegates the society has, and you get a wider cross section of specialties and a wider potential of people from various geographic areas to call on for whatever topic of interest you have. In a real small society, you are hard pressed to find a group of say women or foreign medical graduates to address a particular issue."

Doctor Walker is part of a family that has a long history in organized medicine. His grandfather was president of WCMS in 1911-1912 and his father was on the WCMS Board of Trustees and was WCMS president in 1915-1916. "I am fourth generation and my son is the fifth generation," Doctor Walker said. "I guess being physicians has been in our blood all along."

Also a delegate to the American Medical Association (AMA) and an AMA Board member, Doctor Walker is one of the many physicians who received a taste of organized medicine through WCMS and has moved up the ranks to take leadership roles at the state and national level.

"We have had many good leaders who have gone on to positions at MSMS or the AMA," Maslanka said. "They do not forget us and they stay active, helping us with leadership and membership retention, but their time becomes limited so we must be watchful of the best ways to put these leaders to work."

Another example is WCMS member Susan Adelman, MD. A past WCMS president and current newsletter editor, Doctor Adelman is the current president of MSMS. Active at both levels, Doctor Adelman said she has become more aware of the differences between the county and state societies.

"Both are big enterprises," Doctor Adelman said, "but the county gets more involved with local hospital problems and problems of Detroit. The state does lobbying in Lansing, works with state bureaucracy and has a direct liaison with Blue Cross Blue Shield of Michigan. Working with the state, you have to balance the interests of the country; the county clearly deals with urban issues."

As state president, Doctor Adelman became aware of the problems rural physicians faced. "What was particularly interesting to me was having a practice in Wayne County and an office in the inner city. As state president, I found out about rural practices, that a large number of patients in the rural areas are on Medicaid and some rural physicians have a larger number of patients on Medicaid; more than those in the city. Rural physicians are more isolated, so they cannot cover their losses."

In addition to holding many house of delegates meetings in Wayne County, the state works closely with WCMS and all the counties to assure reasonable representation on the state board, the AMA delegation and in major state offices, which is just a sample of how strong the ties are between MSMS and WCMS.

Leadership a future challenge

Who will be our future leaders and where will we find them?...are questions the Society now is asking as it contemplates its future. "The county needs to identify potential leaders early and get them exposed to the state and national organizations as early as possible," Doctor Adelman said. "Wayne County has been good at identifying and educating physicians about the need to start looking for younger people."

WCMS's service bureau offers services to members such as telephone answering.

However, getting new doctors involved in organized medicine is a challenge in itself. "We do have some young physicians involved now, but their time is taken up with running their practices and their families," Maslanka said. "This raises the question of whether we should incorporate a social outlet or remain a purely professional group for physicians."

Maslanka also has realized that, even though there are many advantages to having a large membership, being so big can have its drawbacks. One of the problems of having a vast membership is relying on a core group of people who actively partic-

Continued on page 21

THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

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For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus; limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation, prematurity, patent ductus arteriosus; fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC® (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: Pregnancy Category D: See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.)

Clinical Laboratory Test Findings: Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representat ipate. "WCMS is a volunteer driven society with many members," Maslanka said. "It is impossible for us and our current president to know everyone. There are a lot of members out there who do not get called on to do things because we do not know who they are, and we find ourselves calling on the same people over and over. To cultivate new leaders, we need our members, who work directly with these people every day, to help us find new talent. We realize that not everyone will want to be on a committee, but there are many members who have not been tapped yet."

When it began, WCMS was an organization which combined social as well as business ventures, according to Doctor Walker. "We would get large crowds together and most everybody that was a member came," Doctor Walker said. "Now, with multiple committees, hospital staff meetings on multiple nights, you could go to a meeting every night. Hospital meetings are required, so physicians have to go to those. WCMS meetings are not, so people do not go as much."

Charles Vincent, MD, former WCMS president, receives the President's Award from MSMS.

A bright future

Membership concerns involve both the short and long term goals of WCMS, according to Maslanka, "but we have an excellent relationship with WSU where hopefully future members will emanate, and we will continue to be called on as a medical resource and build on our past reputation. WCMS continues to meet the needs of its members even as those needs change. Our future is bright."

Keeping the future of medicine in mind, WCMS offers many opportunities to its active medical student section, which has more than 460 members. Serving them in an educational capacity, WCMS teaches future physicians about the numerous advantages and services that organized medicine has to offer.

"Being involved in organized medicine has broadened my spectrum of how I view medicine and how physicians can affect society," said Jerome Yaklic, a third-year medical student at WSU. "It has made me aware of the different roles doctors have to serve the public, such as in public health and politics."

Yaklic currently is a member of the WCMS Resolutions Committee and the WCMS Leadership Development Task Force. Last year, he served as co-delegate of the WCMS medical student section and said his experience in organized medicine has inspired him to consider attending law school and running for Congress after completing his medical training.

"As co-delegate, I learned how organized medicine works, how effective it can be and about the wide range of issues that are addressed," Yaklic said. "I also saw how slow the political process can be and how much red tape is involved. The legal system has a big effect on the way physicians practice and I can see how not being able to speak their language hinders us. Doctors should have a hand in making the decisions that affect them. Physicians, by remaining active politically, can improve the health of more people than treating patients individually."

Vernon Proctor, also a third-year medical student at WSU, served last year as codelegate with Yaklic and said the experience was an "eye-opener watching these people work behind the scenes, making changes, pushing to try to get the wind to blow the way they want it to blow."

Wayne State University School of Medicine students and WCMS members entertain children at the Annual Christmas Party for Underpriviledged Children.

Proctor believes "that if physicians want to survive and practice in a climate that is not hostile to them, they need to take a more active role in what is going on, beginning with the medical students. If you want to grow and increase your awareness in your environment; if you want to be a more effective decision maker, working in organized medicine is an enriching experience." ■

Marlise Michael is managing editor of Wayne County's Detroit Medical News.

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Health Education Foundation

Encourages health care, healthy lifestyles

By Claudia Skutar

Emergency medical technicians practice life-saving techniques on victims while travelling to the hospital in an ambulance.

Schoolchildren learn through role models like the Detroit Pistons to say no to drugs.

Health care professionals attend a conference geared toward the problems of aging in the 1990s, including drug and alcohol abuse.

Physician contributions to the non-profit charitable Health Education Foundation (HEF), the altruisitic arm of MSMS, made these real-life examples possible as a way of enhancing health care and encouraging healthy lifestyles in Michigan.

"The foundation is concerned with promoting all aspects of health," said HEF President Robert E. Paxton, MD, also past president of MSMS.

HEF's five-fold mission (which appears on page 25) was developed with this in mind. Originally started in 1945 to provide financial aid to medical students, the foundation's purpose shifted in the mid 1980s with the advent of more financial help for students from medical schools. HEF was then able to "provide funding for worthy projects dealing with health," according to Nancy Crandall, an HEF Board of Trustees member.

One such project was a recent grant to the Richmond Lenox Ambulance Authority in Macomb County.

"In our industry it's increasingly difficult to get volunteers because we can't just take somebody off the street," said President Jeffery White. "They need to be trained and licensed."

Emergency medical technicians (EMT) who help injured or sick people while transporting them via ambulance to the hospital for medical help must complete 160 hours of certified training along with a written and practical board exam administered by the Michigan Department of Public Health. Until November 1990, the only EMT training course available in the Richmond area, according to White, was offered at Macomb Community College at a cost of about $650 to $700 per person.

"We thought that by offering the course internally, we could train a lot more people for a lot less money," White explained. He estimated the cost of the ambulance authority's course to be about $250 per person.

To help defray costs, the authority applied to several foundations for funding.

"HEF came back with the first grant," said White. "It's the first time we had sufficient funds to enable us to offer the class internally."

The first class, which started last November, will end this month with a high student completion rate of 19 out of 23 students. White noted that classes of this kind usually have a 50 percent dropout rate. The high completion rate in this class was partly due to the fact that it was offered internally, White explained.

According to White, there is still enough money left over from the initial HEF grant to use in combination with other grants the group has received toward starting a second class next September.

Educational projects

Schoolchildren and physicians statewide were targeted in two educational projects which received HEF funding in recent years. In 1988-89, as part of the Detroit Pistons Drug-Free Poster Project, the Michigan State Medical Society Auxiliary (MSMSA) and county medical society auxiliaries distributed to all Michigan schools on request a poster of the Detroit Pistons. Each team member signed the poster, which included the player's personal slogan against drug use. The only cost charged to schools to fill poster requests was postage.

According to Marianne Wiedemer, MSMSA Health Projects Coordinator, the poster was so popular in schools that an initial print run of 15,000 was soon gone and a second print run of 25,000 copies was ordered. The posters were used in a number of ways, said Wiedemer.

"Teachers gave them out as rewards to students, and they were also used, with our permission, in school fundraising activities to make money for drug-free activities," Wiedemer said. "The project was a catalyst for positive activities around the state for youth."

MSMSA sponsored a second educational project in 1989-1990 with the help of HEF funds. The Primary Care Physician Information Packet Project was designed to educate parents and youth about substance abuse prevention. Information packets containing prototypes of handout materials which could be ordered by physicians for distribution in their offices were mailed to physicians statewide, including family practitioners, pediatricians, interns, allergists and dermatologists.

"We urged physicians to have handout materials available and to make it a daily part of their practices," Wiedemer said. "As part of the packet, we gave physicians six suggestions on how to make substance abuse prevention a part of their daily practice."

"The money that came from the HEF really made these projects possible," said Wiedemer. "Without that money, they never would have happened."

Margaret Bernhard, assistant professor in the School of Community Health Services at Western Michigan University, has a similar story to tell about the HEF. Late in the development of a national conference set for April 1990 on the issues of aging and substance abuse, funds from a major contributor became unavailable. The conference was aimed at updating health care professionals from around the country on the latest information in five areas of aging and substance abuse — research, education, treatment, prevention, and medicine. Bernhard quickly scrambled to find replacement funding so that the conference wouldn't be cancelled. HEF was one of several foundations that came through with a grant to ensure the conference would take place.

Short-term grants

The foundation has opted to make smaller short-term grants to groups, according to Doctor Paxton, because funding is limited and the foundation wants to have the greatest impact possible in promoting its goals.

"Our problem is that our assets are less than half a million dollars, and we're limited in what we can do," said Doctor Paxton.

Continued on page 25

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HEF Board of Trustees member Richard J. McMurray, MD, agrees.

"If we're going to keep giving the same groups money, it cuts down on our ability to give money to other worthy projects," he explained.

The 1991 HEF corpus is $478,000, which comes from physician contributions and bequests. (A list of recent contributors appears on below.) Foundation monies are divided into two categories — restricted and unrestricted monies. Restricted monies are earmarked for three funds administered by the HEF. The Bruce Fund endows an annual gift to the University of Michigan Pediatrics Department, the Impaired Physician Loan Fund provides monetary help to impaired physicians, and the Danto Memorial Cancer Fund of the Michigan Chapter of American College of Surgeons grants an annual award for the best cancer paper by a resident in its Coller Day Competition.

Unrestricted funds comprise the general, or agent, fund. This is what pays for grants such as the Richmond Lenox Ambulance Authority Grant.

More contributors needed

"Unfortunately, too many of our members don't know of the foundation's existence, which inhibits the contributions that are its lifeblood," said Doctor Paxton.

HEF Board of Trustees member Nancy Crandall explained that the foundation has "the same difficulty in soliciting funds as any organization." She said the foundation has to be able to sell its program to its members.

"It's a matter of teaching people to think of the foundation as the logical place to contribute money," she said.

"There are only so many charitable dollars," said Doctor McMurray.

He noted that one difficulty in raising HEF funds is inherent in the statewide group of MSMS members. Because the membership is spread out around the state, it's hard to put a fundraiser together that will appeal to different regions.

"You can't have all of your fundraising in Detroit when your membership is statewide," agreed Suzanne Pederson, HEF Board of Trustees member and past president of the MSMS Auxiliary.

One way in which the foundation works toward counteracting this decentralization is to fund projects "throughout the state so that members can feel a connection to the foundation," said Doctor Paxton.

As a way to encourage physician participation in the Foundation and to demonstrate its support, the entire 34-member MSMS Board of Directors contributed to the Foundation last year.

Crandall thinks that another way to encourage physician participation is to create greater awareness among MSMS auxilians as well as physicians so that physician spouses think of HEF as a good way to make a contribution.

"Until the foundation's funding level is higher, it can't completely accomplish the goals it's established for itself," said Doctor McMurray.

Physicians who wish to make contributions to help further the mission of the Health Education Foundation can do so in several ways, including bequests and contributions in the form of cash, stocks, bonds, life insurance and property. If you would like more information on making a contribution to the Health Education Foundation, contact Executive Secretary Dawn Reha at (517) 337-1351. ■

Claudia Skutar is communications specialist for MSMS.

Mission Statement

The Health Education Foundation is a non-profit charitable organization sponsored by the Michigan State Medical Society. Its purpose is to advance the field of health for the public good. The mission of the Foundation is to achieve the following:

- Stimulate, support and/or initiate lay or professional education, research programs, and projects in the field of health.
- Encourage the advancement of healthy lifestyles, the prevention, diagnosis or cure of disease, and the care of the sick and the dying.
- Provide a vehicle for the Michigan State Medical Society to foster humanitarian public service in health education and research, and to provide support for physicians who suffer impairment.
- Develop and administer funds for the support of health education and research.
- Provide a resource for the management and distribution of signature funds or bequests designated for special health education and research purposes.

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Name: Linda K. Cross, MD, 15217 W. Michigan Ave., Marshall, MI 49068
Action, Date Taken: Revoked; January 16, 1991
Reason: Negligence-Incompetency

Name: Howard L. Dubin, DO, 27483 Dequindre #210, Madison Heights, MI 48071
Action, Date Taken: Reprimand, fined $5,000; March 4, 1990
Reason: Violation of Article 7 - Drug Related

Name: Theodore N. Graham, MD, 8120 E. Jefferson, #6M, Detroit, MI 48214
Action, Date Taken: Revoked, Fined $10,000; March 11, 1991
Reason: Negligence-Incompetency

Name: Harry A. Heller, DO, Tel-Joy Clinic, 8623 Telegraph Rd, Dearborn Heights, MI 48127
Action, Date Taken: License Voluntarily Surrendered; March 4, 1991
Reason: Negligence-Incompetency

Name: Benjamin E. Imperial, MD, 16 E. Buffalo Street, New Buffalo, MI 49117
Action, Date Taken: Probation: 1 year and earn 35 credit hours in addition to the 150 hours mandated for license renewal. Reprimand, Fined $1,000; February 12, 1991
Reason: CE Audit Violation

Name: Bipin O. Modi, MD, 902 10th. Ave., PO Box 1309, Port Huron, MI 48060
Action, Date Taken: Probation: 2 years, Limited License; March 11, 1991
Reason: Negligence-Incompetency

Name: Sinforoso S. Padilla, Jr., MD, 217 Lincoln St., Hart, MI 49420
Action, Date Taken: Suspended, 90 days, Fined $10,000; March 11, 1991
Reason: Negligence-Incompetency

Name: Larry S. Sasaki, MD, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit, MI 48205
Action, Date Taken: Granted Controlled Substance Limited License, Limited Educational Limited License, Fined $2,400; January 16, 1991
Reason: Mental-Physical Incompetency

Name: Ian Sayani, MD, 702 Coast Guard, Port Oxford, OR 97465
Action, Date Taken: License Surrendered; November 14, 1990
Reason: Negligence-Incompetency

Name: James A. Thomas, MD, 2004 Hogback Road, Suite 133, Ann Arbor, MI 48105
Action, Date Taken: Probation: 2 years and earn 100 credit hours in addition to the 150 hours mandated for license renewal. Reprimand, Fined $1,000; January 29, 1991
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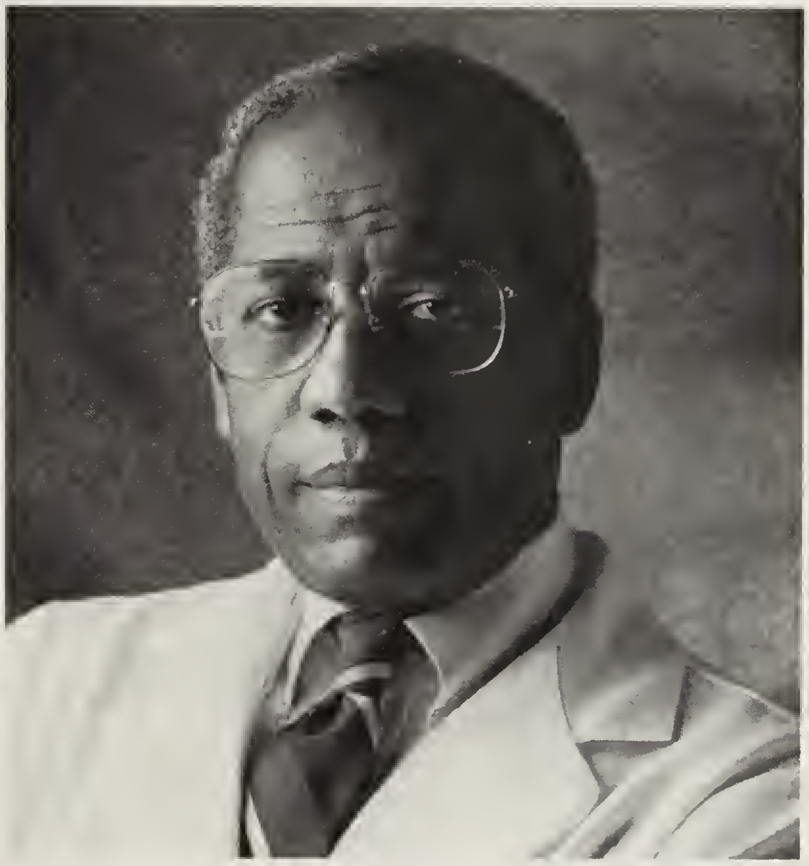

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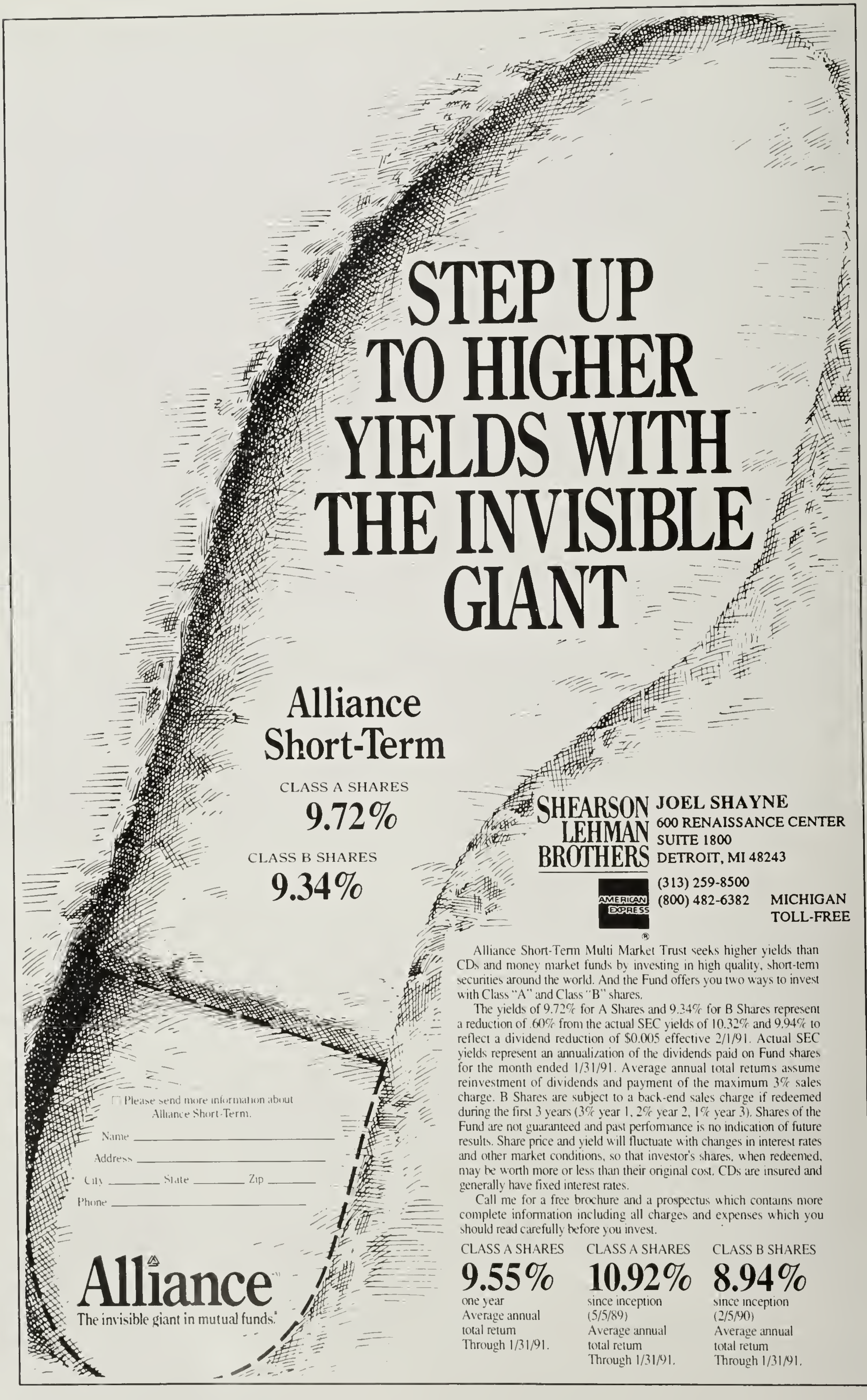

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AIR FORCE

Small Area Analysis

What is it and does it have practical value?

By Jane Deane Clark, PhD

Several Michigan medical staffs have expressed concern over the use of small area analysis methodology by the Michigan Peer Review Organization (MPRO) for evaluating physician quality of care. Physician complaints are that the results are passed on to many major medical groups prior to being studied and evaluated. One variation, not reconciled, is that of admission rates to hospitals being attributable to variations in physician practice. Also a concern is the manner in which apparent inaccuracies and conclusions are being disseminated, with potential detrimental consequences to the medical staffs involved. The MSMS Liaison Committee with MPRO, chaired by Robert C. Packer, MD, has been studying this issue and recently learned that small area analysis can have significant impact on the improvement of patient care. The following is an executive summary written by Jane Deane Clark, PhD, director for Health Care Policy Analysis, Michigan Health Care Institute, who recently addressed the Committee on this topic.

Small area analysis is a population-based geographic method used to study variation in the rates of health care occurrences. Small area analysis has caught the attention of health care providers, policy makers, consumers, and purchasers because it is used to investigate the variation in the rates of occurrence of health care events such as hospital admissions and surgical procedures. Because the rates of occurrence are specific to a geographic area, they can be compared and causative factors can be investigated. Medical research of this type can be traced back to 1856, but more recently has been conducted by, among others, John Wennberg, M.D. at the Dartmouth Medical School, John R. Griffith at the University of Michigan, and Leslie and Noralou Roos at the University of Manitoba.

Small area analysis is not unlike epidemiology where the analysis centers on the disease rate. In epidemiology, the disease rate is obtained by dividing the number of occurrences of a disease in a specific area by the population at risk in the same area. In small area analysis the same method is used. The number of occurrences of a health care event is divided by the number of people at risk for that same health care event in the same geographic area. The result in each type of analysis is a rate expressed as the number of occurrences per 1,000 or 10,000 population. These rates can then be standardized using age and gender as adjustors to a given population. In small area analysis, hospital use rates are evaluated taking into consideration the major demographic factors that may cause misinterpretation of raw or unadjusted data. Further adjustment can be done for socio-economic factors, but such adjustments are made less frequently.

The geographic area that is used most frequently in small area analysis is the hospital service area. Hospital service areas are defined using historical patient origin information at a zip code or minor civil division (MCD) level. Patterns of hospital use are investigated and a zip code or MCD is assigned to the hospital service area where the plurality of patients from that zip code have historically received care. In a city such a Lansing, a researcher using small area analysis methodology would not divide the city into four hospital service areas (one for each hospital), but would use a single hospital service area that might also incorporate the zip codes of one or more of the smaller hospitals on the periphery. The decision for inclusion would depend upon whether a plurality of patients from an outlying zip code (even one including a smaller hospital) received

Continued on page 49

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care in Lansing or at the smaller hospital. Once the geographic area is defined, a small area analysis researcher defines the population at risk as narrowly as possible. For example, hysterectomy rates are calculated by dividing the number of hysterectomies by the number of mature females in the hospital service area, since mature females constitute the population at risk. In this way, the researcher may be looking at the characteristics of an entire community to find explanation for the variation in use rates, or may be looking at the characteristics of a subpopulation. The decision depends upon the disease type or hospital procedure being analyzed.

Small area analysis is best used to study hospital use rates for commonly occurring health care events that do not utilize complex technology since the occurrence of the event is always assigned to the zip code of the patient's residence, whether the hospital admission or procedure took place in a hospital within the service area or not. For example, small area analysis methodology is more appropriate for the study of cholecystectomy than for the study of cardiac bypass procedures.

A look at the results

First and foremost, researchers have found that there is variation in all use rates. The amount of variation varies depending upon the type of rate examined. But there is consistency in the amount of variation found in any one use rate over time and across areas. For example within surgical procedures, there is low variation in inguinal and femoral hernia repair rates, moderate variation in cholecystectomy, high variation in hysterectomy, and very high variation in transurethral operations. As shown in Figure 1, medical causes for admission generally exhibit a greater amount of variation than do surgical procedure rates, with no medical causes for admission listed as having low variation.

Surgical procedure rates, when graphed in comparison to a state norm, unique to a specific hospital service area. A hospital service area that has high total admission rates may not be consistently high in all surgical procedure rates. Instead, some specific procedures may have high use rates while other procedure rates may be low. There is some disagreement on this point. Griffith, working in Michigan, has found less evidence of a surgical signature. Griffith found that areas which have high total admission rates tend to have high use rates on almost all clinical measures. Clark, also working in Michigan, but with a single year's data, found evidence that hospital service areas with high use rates for total admissions did show distinctive surgical signatures.

Once the variation in use rates was documented using small area analysis methodology, researchers attempted to explain why the variation occurs. Some studies indicate an increased utilization rate in communities that are well supplied with hospital beds and specialists. Research has shown a positive relationship between the number of beds and physicians per capita and a higher than average use rate in hospitals for specific surgical procedures in Canada and the United States. In rural Michigan it has been found that non-surgical admission rates are higher in communities with more empty beds per capita and with a greater number of physician specialists. Wilson, in a recent study in Michigan, found that an increased supply of hospital beds was related to a higher use rate by whites, but unrelated to the use rate by blacks. Interestingly, the relationship between use rates and the supply of physicians and beds could not be proven in studies of hysterectomy rates and tonsillectomy rates in Canada.

Other researchers have attempted to explain the variation in use rates by examining differences in the communities' characteristics. Two Canadian studies of elderly patients found relationships between disproportionately large number of residents of Anglo-Saxon heritage and high use. In the same study, income, insurance coverage, and community size were found to be unrelated to use.

Griffith found that there was a significant positive relationship between community size and average length of stay as well as discharge rate. Michigan communities with lower incomes and higher unemployment had higher surgical rates than did communities with higher incomes and employment. Clark found a strong positive relationship between rurality and higher than average use rates.

Working largely in New England, Wennberg and Gittelsohn found surgical rates unrelated to race, income, education, residence, insurance coverage, and health status. They did find surgical rates related to physician characteristics, specifically to medical consensus. Wennberg has hypothesized that as medical consensus builds, variation in use rates will decrease. He reasons that differences in physician

Continued on page 50

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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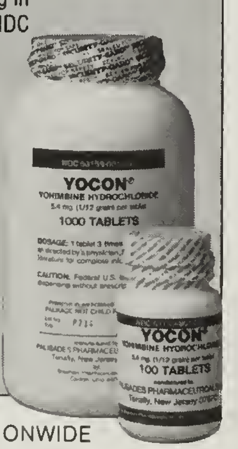

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training increase the variation in use rates since medicine is an art where decision criteria for diagnosis and treatment are based, in part, upon learned patterns and, in part, upon individual observation and empirical evidence. Inguinal hernia repair and hysterectomy are good examples of the relationship between medical consensus and use rate variation that Wennberg has hypothesized. There is a high degree of medical consensus on the diagnosis and treatment appropriate for a patient suffering from an inguinal hernia. The use rates for inguinal hernia repair show a low degree of variation across hospital service areas. This is not true of hysterectomy. There is low medical consensus on whether a hysterectomy is the most appropriate treatment in female patients presenting with the same symptoms. In addition, physician referral patterns tend to reinforce a community's use rate pattern, since physicians refer to other physicians who practice in a like manner.

Using the results

Although the results of small area analysis are being used by public policy makers, peer review organizations, consumers and purchasers, the group that will probably gain the most from the use of the results will be physician and hospital providers of health care. Public policy makers in their efforts to contain health care costs and investigate appropriate patient care and outcomes are using small area analysis methods. Peer review organizations across the country and specifically the Michigan Peer Review Organization (MPRO) are using small area analysis results for Medicare patients in educational efforts directed at showing providers the variation present in hospital events. Consumers and purchasers could use the results in utilization review efforts, specifically in requirements for second opinions.

Within the medical profession the results of small area analysis research may be used to study the etiology of a disease. The location of the low and high outliers may provide clues not only to the causative factors of the disease, but to limitations in access to health care for the population at risk. If medical consensus is related to variations in use rate as it appears to be, then the results of small area analysis research can be very important to graduate medical education and continuing medical education for practicing physicians. Feedback of use rate data to physicians can be instrumental in reducing the amount and degree of variation in those use rates.

In the physician feedback model, specialty-specific study groups are established to provide the physicians with observed and expected use rate data specific to their specialty. Analytical and technical assistance is also provided. The study group then meets at a local, regional, and/or state meeting with confidential use rate data given to participating physicians. The study group members discuss their decision criteria, focusing on the appropriateness of the intervention and patient outcomes. The effort is to build physician consensus on the decision criteria and appropriate method of treatment. After a length of time the study group is reconvened with new confidential use rate data provided to each participant so that the physicians can see if their previous discussion reduced use rate variation through consensus building.

This feedback model has been used since 1980 in Maine where a total of nine study groups are operational. The physician study groups include obstetrics/gynecology, orthopedics/neurosurgery, urology, pediatrics and five other specialties. The appropriate group has reviewed use rate data for and discussed hysterectomy, cesarean section, laminectomy, prostatectomy, and

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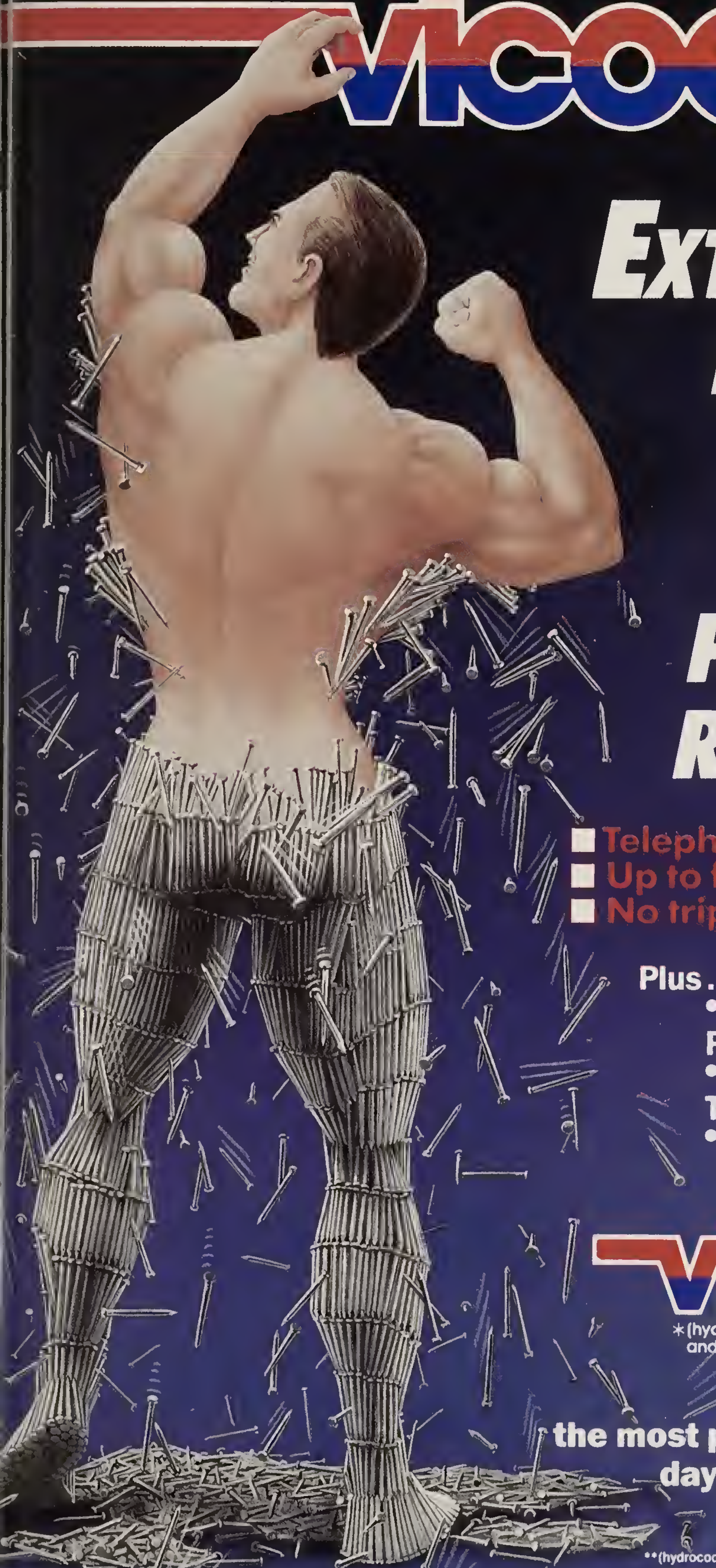

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Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy:
Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.
Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:
Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.
Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.
DRUG ABUSE AND DEPENDENCE:
VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.
OVERDOSAGE:
Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.
Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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Continued from page 50

common pediatric medical conditions. Review of the data in the year following a physician study group discussion has shown a reduction in variation among hospital service areas. Anecdotally, the physicians and staff at the Maine Medical Assessment Foundation tell of use rates that remain stable until the death of a physician or the arrival of a new physician from outside Maine.

Recommendations

As a researcher using small area analysis methods and an employee of the Michigan Health Care Institute at the Michigan Hospital Association, I recommend that the Michigan State Medical Society undertake two activities related to small area analysis. First and foremost, I recommend that MSMS institute one or several specialty-specific study groups to incorporate some or all of the steps in the physician feedback model described above. Part of my reasoning stems from the logic that says do the investigation yourself before someone else can do it to you, but that is a negative reason to do what physicians have always done — use data to provide the best information that will enable the provision of the highest quality health care. Use this methodology to investigate variations in Michigan for both high and low variation use rates. Physicians may be able to reduce variation by using the physician feedback model. Physicians may even be able to reduce high use in some areas where the use rate may not be appropriate for that population. But more importantly, physicians will discover areas where extremely low use rates indicate access problems and areas where high use rates are appropriate for the population served.

My second recommendation is that the Michigan State Medical Society consider supporting further research in the relationship between medical consensus and variation in use rates. This hypothesis has not been tested as thoroughly as it needs to be. What role does graduate medical education play? What happens to physician practice patterns as they move from a medical residency to a community practice? What role does physician referral play. All these questions and more need to be answered and need to be answered quickly since the policy makers at a national level have adopted small area analysis as a method of investigating the American health care system.

References available upon request.

The author is director for Health Care Policy Analysis, Michigan Health Care Institute.

RURAL HEALTH:

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National Rural Health Association
14th Annual National Conference
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Seattle, Washington

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Andrew. M. Agosta, MD — OBG
1000 Houghton Ave.
Saginaw 48602

Cesar V. Alcid, MD — AN
1173 N. Ballenger Hwy.
Suite 203
Flint 48504

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2420 First Ave., South
Escanaba 49829

Roger W. Archer, DO — FP
31555 Taylor
Wayne 48184

David J. Barrett, MD — OPH
2855 Michigan St., NE
Grand Rapids 49506

Frederick W. Born, DO — FP
5879 Bibon
Jackson 49201

Frank A. Brettschneider, DO — OTO
1210 Richardson
Port Huron 48060

Frank A. Bucci, Jr., MD — OPH
750 Stewart Rd.
Monroe 48161

Donald A. Campbell, Jr., MD — FP
25650 Kelly Rd. #12
Roseville 48066

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2067 Woodburn
Grand Rapids 49546

Radha Cherukuri, MD — OBG
1000 Houghton
Saginaw 48602

Jerome F. Cordes, Jr., MD — DR
1215 E. Michigan
Lansing 48912

Maria B. Costa-Fox, MD — PTH
1215 E. Michigan
Lansing 48912

Reza Dabir, MD — GS/TS
1663 W. Big Beaver Rd.
Troy 48084

William Davidson, DO — U
5649 N. Inkster Rd.
Garden City 48135

David L. Dull, MD — AN
2804 Oakwood Dr., SE
Grand Rapids 49506

Nancy Dvorak, MD — IM/P
3320 Spinnaker Lane
Detroit 48207

Cheryl L. Dwyer, DO — OBG
1227 N. Michigan
Saginaw 48602

Jeffrey H. Dysart, MD — FP
7730 Canton Center Rd. S#111
Canton 48187

Michael Farmer, DO — EM
3329 S. Duffield Rd.
Lennon 48449

Steven J. Ferrucci, MD — OBG
555 Barclay Circle #150
Rochester Hills 48063

Gregory M. Georgiadis, MD — ORS
30121 Fiddlers Green
Farmington Hills 48334

N. Ravi Gunawardene, MD — PD
215 E. Mansion
Marshall 49068

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570 Linn St.
Allegan 49010

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745 W. 26th. St.
Holland 49423

Tadd A. Heft, DO — IM/EM
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Allegan 49010

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Southfield 48034

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728 Pleasant St. #7
St. Jospeh 49085

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200 S. Wenona
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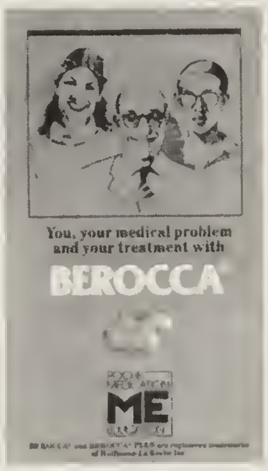
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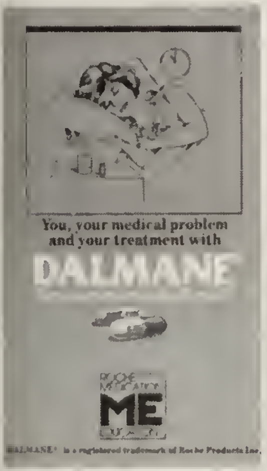
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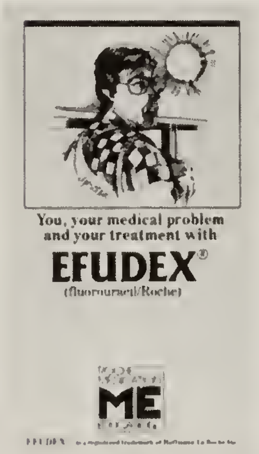
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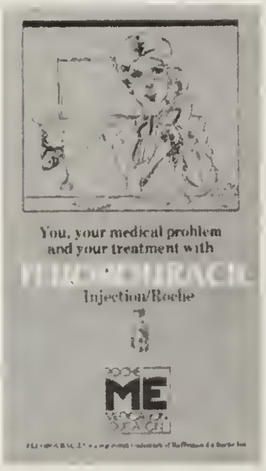
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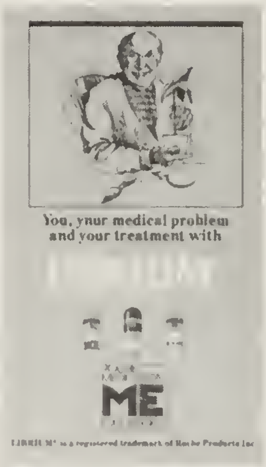
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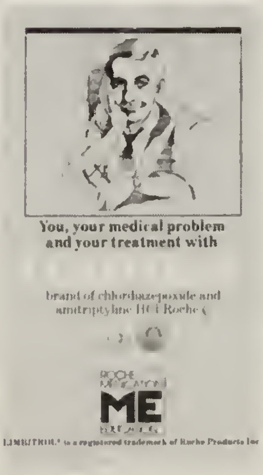
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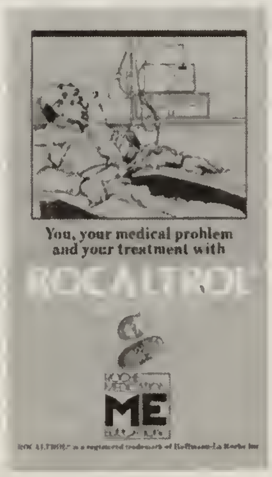
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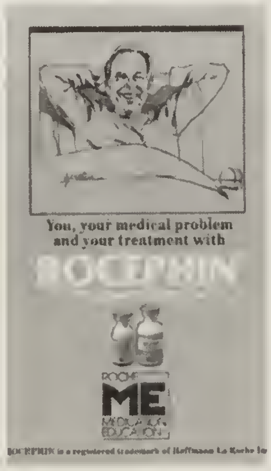
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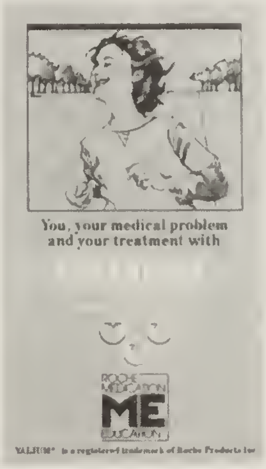
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DEATHS

John G. Baxter, MD
Clearwater, Florida

John G. Baxter, MD, a general practitioner, died January 4. He was 82. Doctor Baxter was a 1940 graduate of Wayne State University. He maintained an office in Center Line and served on staff at Saratoga General Hospital, Detroit. He retired in 1973 from private practice. Doctor Baxter was a member of the American Medical Association, the Academy of Family Physicians, the Macomb County Medical Society, and MSMS.

Matthew C. Bennett, MD
Marquette

Matthew C. Bennett, MD, a general surgeon, died February 8. He was 78. Doctor Bennett was a 1933 graduate of Northern Michigan University. He received his medical degree in 1937 from the University of Michigan Medical School. He served his internship at Pennsylvania Hospital, Philadelphia. Doctor Bennett received his surgical training at Detroit Receiving Hospital, Wayne State University. He was the founder of Marquette Surgical Associates. Doctor Bennett was a member of the American College of Surgeons, the American Medical Association, the Upper Peninsula Medical Society, and MSMS.

Brack A. Bivins, MD
Franklin

Brack A. Bivins, MD, a general surgeon, died February 10. He was 47. Doctor Bivins attended Western Kentucky University, Bowling Green and after graduation, entered the College of Medicine at the University of Kentucky. He earned his medical degree in 1970. He served on staff at Henry Ford Health System, Detroit, as division head of Trauma and Critical Care Surgery and vice president for Clinical Services. In addition to his position at Henry Ford Health System, Doctor Bivins worked as a clinical associate professor of surgery at the University of Michigan and as an associate professor of pharmacy at Wayne State University. He was a member of the Central Surgical Association, the American Association of Surgery and Trauma, the Association for Academic Surgery, the Society of Critical Care Medicine, the Southern Medical Association, the Society for Surgery of the Alimentary Tract, the American Society of Hospital Pharmacists, the American College of Physician Executives, the Academy of Surgery of Detroit, the Detroit Surgical Association, and MSMS. He also was a Fellow of the American College of Surgeons.

Louis Carbone, MD
Charlottesville, Virginia

Louis Carbone, MD, an internist, died October 29. He was 85. Doctor Carbone earned a bachelor's degree from the University of Chicago and his medical degree from Northwestern University. He served on staff of Harper Hospital, Detroit, for more than 50 years. He was the first president to serve on the medical staff at St. John's Hospital, Detroit. He resided in Grosse Pointe before retiring to Virginia. Doctor Carbone was a member of MSMS.

Dorothy L. Hofstra, MD
Detroit

Dorothy L. Hofstra, MD, a pediatrician, died October 27. She was 66. Doctor Hofstra was a graduate of Calvin College and the University of Michigan Medical School, class of 1949. Her internship was served at Eloise Hospital, Wayne County. Doctor Hofstra had been affiliated with Maybury Sanitarium and Herman Kiefer Hospital, Detroit. She was a member of MSMS.

David Jacknow, MD
Bloomfield Hills

David Jacknow, MD, a specialist in occupational medicine, died January 12 at the age of 69. Doctor Jacknow received his bachelor and medical degrees from Wayne State University. He served as chief of staff at Macomb Hospital, Detroit. He was the owner and president of Detroit Industrial Clinic, PC. Doctor Jacknow was president of the Michigan Occupational Medical Association and consulting professor-Health Sciences, Oakland University. He served on the board of Workers Compensation Health Care Services, the Council of Scientific Affairs of American Occupation Medical Association, the National Committee on Trauma-AOMA, and the Governor's Safety Advisory Council. He was a fellow of the Royal Society of Health, England. Doctor Jacknow was a member of the American Medical Association and MSMS.

Clifford E. Keeler, MD
Jackson

Clifford E. Keeler, MD, a psychiatrist, died January 11. He was 71. Doctor Keeler attended Eastern Michigan University and received his medical degree from the Wayne State University School of Medicine. He also was a graduate of the Naval School of Aviation Medicine, Pensacola, Florida, and the Menninger Foundation of Topeka, Kansas. Doctor Keeler was a retired career naval medical officer, staff psychiatrist and chief of the Neuro Psychiatric Service at Foote Memorial Hospital. He served as associate professor of Clinical Psychiatry at Michigan State University. He was prominent in numerous civic organizations in the community. He also had his own private practice in Jackson. Doctor Keeler was a member of the American Medical Association, and MSMS.

James F. Scallin, MD
East Lansing

James F. Scallin, MD, an anesthesiologist, died February 9. He was 65. Doctor Scallin attended the University of South Dakota and received his medical degree from the University of Michigan Medical School. He began his practice in Lansing in 1956, retiring in 1989. Doctor Scallin was a member of the American Medical Association, the Ingham County Medical Society, the American College of Anesthesiologists, and MSMS.

Ellen A. Ward, MD
Ann Arbor

Ellen A. Ward, MD, a general practitioner, died February 8. She was 50. Doctor Ward was an undergraduate at Calvin College, Grand Rapids, and in 1963 graduated from the University of Michigan Medical School. In 1975 she started a general practice in Ann Arbor. Doctor Ward was a member of the American Medical Association, the Michigan Academy of Family Physicians, the Washtenaw County Medical Society, and MSMS.

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MEETINGS

MSMS Meetings

April

24, PSG, Michigan Medical Group Managers Association, Spring Conference; Dealing with Change, Holiday Inn University Place, East Lansing, MI. Contact: Caroline Kimmel, Executive Secretary (517) 336-7570.

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

AMA Meetings

June

23-27, AMA House of Delegates Annual Meeting, Chicago Hilton & Towers Hotel, Chicago, IL 60611. Contact: Jacquelyn Craig, AMA, 515 N. State St., Chicago, IL 60610, 312-464-5000.

Michigan Specialty Society Meetings

April

13, The Oedipal/Genital. Restoration of a Phase. Notes on Theory, Zuckerman Auditorium, Sinai Hospital, Detroit, MI. Contact: Shirley Seffinger or Colleen Jaeger (313) 557-8633 or 559-5855.

16-19, Quality, Technology, and Caring: Maintaining the Balance, Amway Grand Plaza Hotel, Grand Rapids, MI. Contact: Michigan State Medical Society, (517) 336-7570.

21-23, Uniting to Support Infants and Families in Crisis, University of Michigan Campus, Ann Arbor, MI. Contact: Kathleen Baltman (313) 577-5244.

27, The Diagnostic Interview: How to Enhance Your Interviewing Skills with the Use of Psychoanalytic Principles, 16310 W. Twelve Mile Rd., Suite 204, Southfield, MI. Contact: Shirley Seffinger or Colleen Jaeger, (313) 557-8633 or 559-5855.

May

18, Notes on Transcultural Issues in Psychoanalysis and Psychoanalytic Psychotherapy, 16310 W. Twelve Mile Rd., Suite 204, Southfield MI. Contact: Shirley Seffinger or Colleen Jaeger (313) 557-8633 or 559-5855.

National Specialty Society Meetings

April

11-13, American Society of Abdominal Surgeons, Tampa, FL. Contact: (301) 483-5471.

11-14, American College of Physicians, New Orleans, LA. Contact: (215) 351-2400.

18-21, American College of Forensic Psychiatry Ninth Annual Symposium, Newport Beach, CA. Contact: (714) 831-0236.

21-23, National Council on Patient Information and Education, Washington, DC. Contact: (202) 347-6711.

21-25, American Association of Neurological Surgeons, New Orleans, LA. Contact: (708) 692-9500.

21-26, American Association of Immunologists, Atlanta, GA. Contact: (301) 530-7178.

21-27, American Academy of Neurology, Boston, MA. Contact: (612) 623-8115.

28-May/2, American Urological Association, Las Vegas, NV. Contact: (301) 727-1100.

29-May/3, American Pediatric Society, New Orleans, LA. Contact: (505) 764-9099.

May

3-6, Association of American Physicians, Seattle, WA. Contact: (609) 848-1000.

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gastroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-June/1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

April

9,16,23, The Bar-Levav Educational Association, Ongoing Seminar Series, "In the War Against Narcissism: Battling Self-indulgence." Sponsor: Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for:** 6 hours Category I Credit.

10-12, Ultrasound In Obstetrics And Gynecology. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 21 hours Category I Credit.

12, Sports Medicine. Location: Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202-2689, (313) 876-3073 or 800-888-4340. **Approved for:** 6.5 hours Category I Credit.

12-13, Innovations in G.I. Management. Location: Amway Grand Plaza, Grand Rapids, Michigan. **Sponsor:** Saint Mary's Health Services. **Contact:** Catrina Patterson, Marketing Department, (616) 774-6458. **Approved for:** 10 hours Category I Credit.

17, Management of Terminal Illness: An Update. Location: Hotel St. Regis, Detroit's New Center Area, Detroit, Michigan. **Sponsor:** Henry Ford Hospital. **Contact:** Office of Continuing Medical Education, 2799 W. Grand Blvd., Detroit, MI 48202-2689, (313) 876-3073 or 800-888-4340. **Approved for:** 5.5 hours Category I Credit.

18, Diagnostic Psychiatry: Tolls and Techniques. Location: Weber's Inn, Ann Arbor, Michigan. **Sponsor:** Michigan Psychiatric Society. **Contact:** Margaret Cole, (313) 647-7600. **Approved for:** 6 hours Category I Credit.

18-20, Twentieth Annual Critical Care Symposium. Location: Kresge Auditorium, Harper Hospital, Detroit, Michigan. **Sponsor:** Detroit Receiving Hospital and University Health Center, Wayne State University School of Medicine. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, University Health Center, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 16.5 hours Category I Credit.

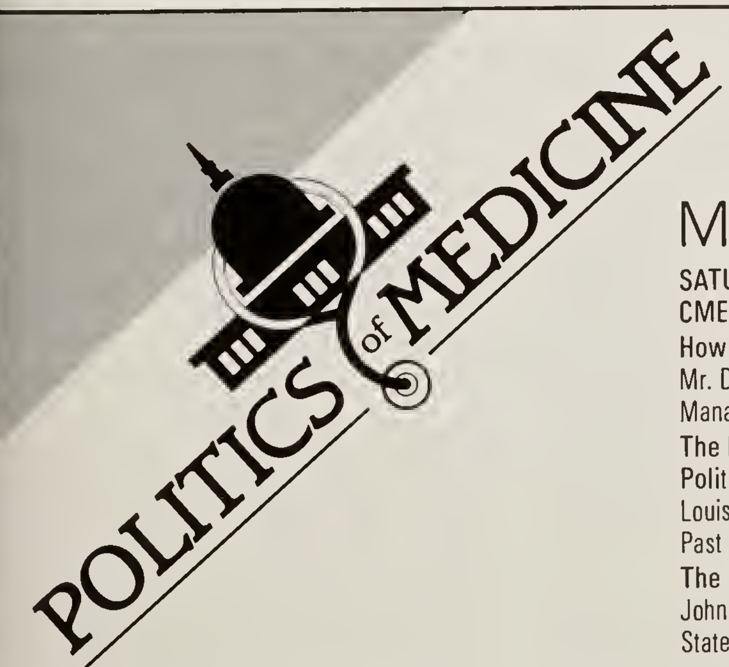
19,20, Advances in Gastroenterology. Location: Kellogg Center, East Lansing, Michigan. **Sponsor:** Ingham Medical Center, Department of Continuing Medical Education. **Contact:** M.A. Taylor, Director CME, Ingham Medical Center, (517) 334-2107. **Approved for:** 12 hours Category I Credit.

26-27, Evaluation and Management of Valvular Insufficiency. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Angela Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 764-2288. **Approved for:** 15 hours Category I Credit.

27, Michigan Society of Anesthesiologists 36th Annual Scientific Session. Location: Ritz Carlton, Dearborn, Michigan. **Sponsor:** Michigan Society of Anesthesiologists. **Contact:** Caroline Kimmel, P. O. Box 950, East Lansing, MI 48826-0950, (517) 336-7570. **Approved for:** 6 hours Category I Credit.

29-May 3, Advances In Internal Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Contin-

Continued on page 63



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Mr. Dan Farhat, MSMS
Manager of State Legislation
The Importance of Becoming Politically Involved
Louis R. Zako, MD
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The Physician and the Legislature
John J. H. Schwarz, MD
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Medical Politics on the National Scale
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Complimentary Alumni Luncheon
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EVENTS FOR REUNION CLASSES
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If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selections. Contact us today for additional information.

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StLukes

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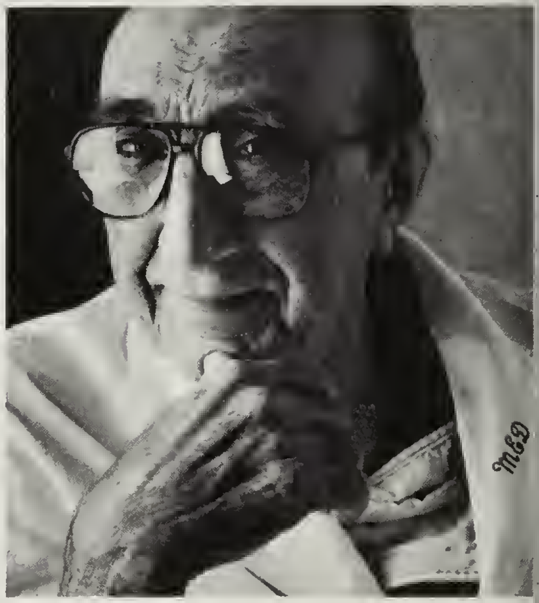

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American Medical Association

CATEGORY I COURSES

Continued from page 61

uing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 34 hours Category I Credit.

May

3-5, The Treatment of Anxiety: A Psychotherapeutic Approach. Location: Hyatt Regency Suites, Chicago, Ill. **Sponsor:** Bar-Levav Association. **Contact:** James McCarthy, 200 Fisher Building, Detroit, MI 48202, (313) 872-1300. **Approved for:** 20 hours Category I Credit.

7,14, The Bar-Levav Educational Association, Ongoing Seminar Series, "Separating Thoughts from Feelings: An Essential Skill for the Psychotherapist." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

16-17, The Restenosis Summit III. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Cardiology, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

17-18, 63rd Annual Ophthalmology Spring Postgraduate Conference: Lasers In Ophthalmology. Applications and New Developments. Location: University of Michigan, W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 11 hours Category I Credit.

20-22, Airborne Pollen and Fungus Spore Identification: A Hands-On Workshop. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Dept. of Postgraduate Medicine, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 17 hours Category I Credit.

21,28, The Bar-Levav Educational Association, Ongoing Seminar Series, "Fathering in the Family and in Psychotherapy-Videotape and Discussion." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-533. **Approved for:** 4 hours Category I Credit.

June

4,11, The Bar-Levav Educational Association, Ongoing Seminar Series, "Instilling Self Restraint: Another Step in the War Against Narcissism." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

5-7, 18th Annual Symposium on Current Topics in Blood Banking. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Dept. of Pathology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

13-15, Microscopic Endolaryngeal Surgery: New and Advanced Techniques of Diagnostic Treatment. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

17-21, 27th Annual Northern Michigan Summer Conference. Location: Shanty Creek Resort, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 764-2288. **Approved for:** 20 hours Category I Credit.

21,23, Joint Conference for Primary Care Physicians Featuring: Rheumatology, Neurology, Dermatology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** Ingham Medical Center, Department of Continuing Medical Education, and Michigan State University, Department of Medicine, College of Human Medicine. **Contact:** M.A. Taylor, Director, CME, Ingham Medical Center, (517) 334-2107. **Approved for:** 12 hours Category I Credit.

July

8-11, Mackinac Island Imaging Conference. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073 (313) 551-6199. **Approved for:** 21 hours Category I Credit.

Bimonthly
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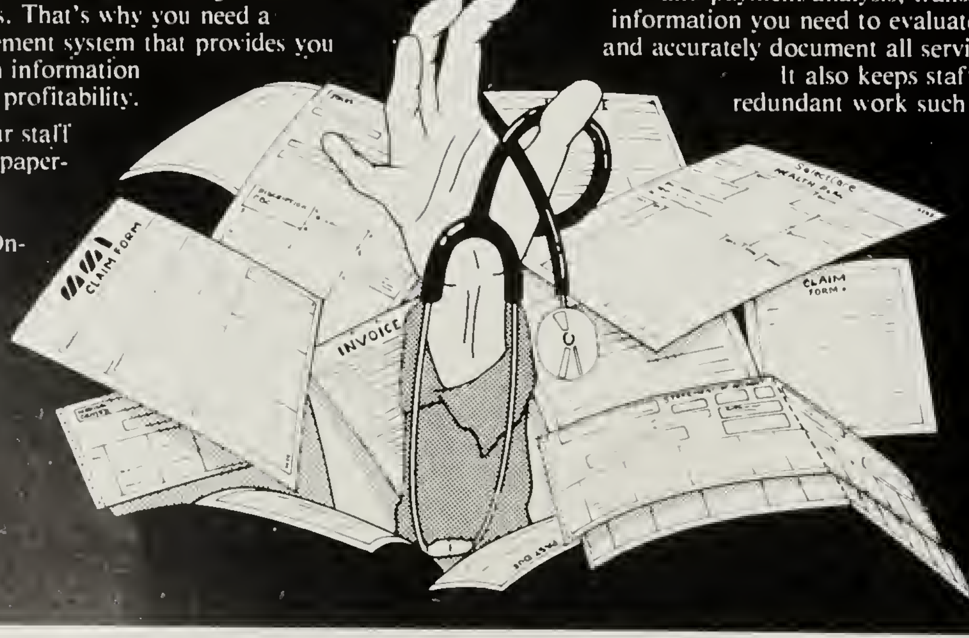

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CLASSIFIEDS

The rate for classified advertising in *Michigan Medicine* is 80 cents per word, with a minimum charge of $40.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

BC/BE INTERNIST: Part-time, to join dynamic six full-time, one part-time, **private practice group.** Excellent salary, benefits. About 45 minutes from downtown Detroit. Send CV to: Internal Medicine Associates, 133 S. Gratiot, Mt. Clemens, MI 48043.

CENTRAL/NORTHERN MICHIGAN: Excellent practice opportunities for **family physicians, radiologists, surgeons** and **internists** located in or near major recreational and resort areas. Salaries and benefit packages competitive with downstate practices. For further information, please submit your curriculum vitae in confidence to Kit E. Schroeder, Midwest Medical Recruiters, 12935 W. Bay Shore Drive, Suite 450, Traverse City, MI 49684 (616) 941-5063.

DEAN MEDICAL CENTER: A 220-plus physician multi-specialty group is actively seeking a BE/BC **General Internist** with interest in pediatrics to work at the Stoughton and Evansville, WI, offices located approximately 20 miles from Madison. Call would be shared with two internists based in Stoughton. There is also four Family Practice physicians and one General Surgeon located at the Stoughton office, along with full sub-specialty support in Madison. Excellent compensation and benefits provided with this position. Please submit CV and letter of introduction to Scott M. Lindhlom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, WI 53715, or call work (608) 252-8022 or home (608) 276-8989.

DERMATOLOGIST, PSYCHIATRIST, ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE: A progressive, 126-bed, two hospital system is seeking the above specialties to establish practices in the **Iron Mountain** area of **Michigan's Upper Peninsula.** Must have BE/BC. Located 100 miles north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully staffed special diagnostic department. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4500.

EMERGENCY MEDICINE AND PRIMARY CARE PHYSICIANS: Opportunities are available through **Spectrum Emergency Care**, the largest emergency department staffing and management firm in the nation. Hospitals with varying patient volume and acuity located throughout Michigan are looking to complement their ED and UC teams with part-time and full-time physicians. Occurrence malpractice insurance along with guaranteed fees. For part-time positions, contact Jan Spitler (800) 325-3982, ext. 3025; for full-time opportunities, contact Mallarry Dierkes (800) 325-3982, ext. 1029. Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141.

EMERGENCY MEDICINE: Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of **Northern Wisconsin**, is seeking an **ER Physician.** This individual must be BE/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multispecialty group representing 13 specialties available for back-up. The Lakeland area offers a unique recreation oriented lifestyle and this position with a 48-hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449 or call (800) 826-2345, ext. 5376.

EMERGENCY PHYSICIAN: Experienced physician for low acuity emergency room in Macomb County. 5,000 visits per year, minimal night volume. Congenial surroundings and staff with ample time for study, etc. Would suit emergency physician or family practitioner looking for a slower pace. Twelve and 24-hour shifts. Full and part time positions available. ACLS necessary. Call (313) 642-9893 or send CV to P. O. Box 2770, Southfield, MI 48037.

FAMILY PHYSICIAN: Wanted to join nonprofit community health center program. BC/BE. Modern facility in rural community in central Upper Peninsula of Michigan. OB and hospital required. Competitive salary, excellent benefits. Possible loan repayment. Immediate opening. Send CV to: Donna Jaksic, Executive Director, Upper Peninsula Association of Rural Health Services, 220 W. Washington, Suite 430, Marquette, MI 49855 (906) 228-3613.

Continued on next page

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FAMILY PRACTICE — HOSPITAL-SPONSORED CLINIC OPPORTUNITY. Dynamic, growth-oriented hospital in beautiful **North Central Wisconsin** is seeking Family Physicians to join a growing practice in a new facility. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact **Kari Wangsness, Associate, The Chancellor Group, Inc., France Place Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota 55435, (612) 835-5123.**

FAMILY PRACTICE: Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC **Family Practitioners** to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of 35. Positions are available in Westcentral, Northwestern, and Northcentral **Wisconsin.** These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers and streams. All are ideally suited for physicians seeking to combine professional excellence in a Midwest, family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700 with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449, or call (800) 826-2345, extension 5376.

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FAMILY PRACTICE OPPORTUNITIES: Michigan Primary Care Association, a network of Family Physicians with clinics statewide seeking BE/BC FPs. Outstanding opportunities for physicians wishing to provide the full spectrum of family care (OB not a requirement). Guaranteed salary with excellent benefits including malpractice insurance, ample vacation, and CME. Many locations are affiliated with FP Residency Programs, designated Loan Forgiveness sites, or near large lake communities. Contact: Lisa Hadden, Michigan Primary Care Association, 535 N. Capitol, Suite 4, Lansing MI 48933 or call (517) 484-8431 or (800) 752-7268.

FAMILY PRACTICE – Physicians seeking a BE/BC family practice physician for the **Norway, Michigan,** service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, MI 49870, (906) 563-9243 or office (906) 563-9255.

FAMILY PRACTICE – Physicians seeking a BE/BC family practice physician for the **Norway, Michigan,** service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, MI 49870, (906) 563-9243 or office (906) 563-9255.

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GENERAL INTERNAL MEDICINE: Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC Family Practitioners to join expanding regional centers. Positions are available in Westcentral, Northwestern and Northcentral **Wisconsin.** These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers and streams. All are ideally suited for physicians seeking to combine professional excellence in a Midwest, family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifesytle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700 with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449 or call (800) 826-2345 ext. 5376.

GRAND RAPIDS: Progressive, established group of residency-trained, board-certified **emergency physicians** seek additional member. Must love emergency medicine and have sense of humor. Group has excellent practice of six years in newly-renovated department in 350-bed hospital. Full departmental status with excellent relationship with medical staff. Transcribed dictated charts and computer information systems in the department. Patient volume is 32,000. We have a high degree of participation in EMS system and also teach residents in the ED with house staff in all specialties except EM and PEDS. The initial compensation is over $125,000. Malpractice, health, and disability insurance as well as $2,000 education allowance the first year. Progressive

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ILLINOIS (Chicago, West & Central Areas): Seeking emergency medicine physicians for full-time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. Benefit package available to full-time physicians. For more information contact: Emergency Consultants, Inc., 2240 S. Airport Rd, Room 23, Traverse City, MI 49684; (800) 253-1795 or in Michigan (800) 632-3496.

INTERNIST: BC/BE desired for growing **primary care practice** in **North Oakland County**. Full-time/part-time, contact: Susan E. Coleman, MD, Medical Director, (313) 625-6660, Women's Health Center of Clarkston, Pine Ridge Place, 7650 Dixie Hwy., Clarkston, MI 48346.

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JULY, AUGUST, SEPTEMBER, Various locum tenens positions available in emergency departments throughout Michigan. Combine vacation with work schedule. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd, Room 23, Traverse City, MI 49684. (800) 253-1795 or in Michigan (800) 632-3496.

KALAMAZOO: Excellent opportunities available for BE/BC **family practitioners, internists and OB/GYNs.** Due to increasing patient volume, expansion of current practices is necessary. Opportunities include both hospital-based and group private practices leading to partnership. Competitive salaries, bonuses based on productivity, malpractice insurance and moving expenses. Bronson Hospital is a 442-bed tertiary care facility for southwestern Michigan. ICU, CCU, CSU, NICU, PICU as well as ACS certified Level I Trauma program. Strong subspecialty support. Affiliated with Michigan State University providing education to medical students and residents including FP and IM residency programs. Kalamazoo, located midway between Chicago and Detroit, offers diverse cultural opportunities. Lake Michigan's beaches and dunes only minutes away and numerous lakes, hills and forests provide boundless recreational activities. Excellent public and private schools, several colleges and major university further contribute to high quality lifestyle. Please send CV to Debra Hartman, Bronson Healthcare Group, One Healthcare Plaza, Kalamazoo, MI 49007 or call (800) 594-9022 or (616) 341-6331.

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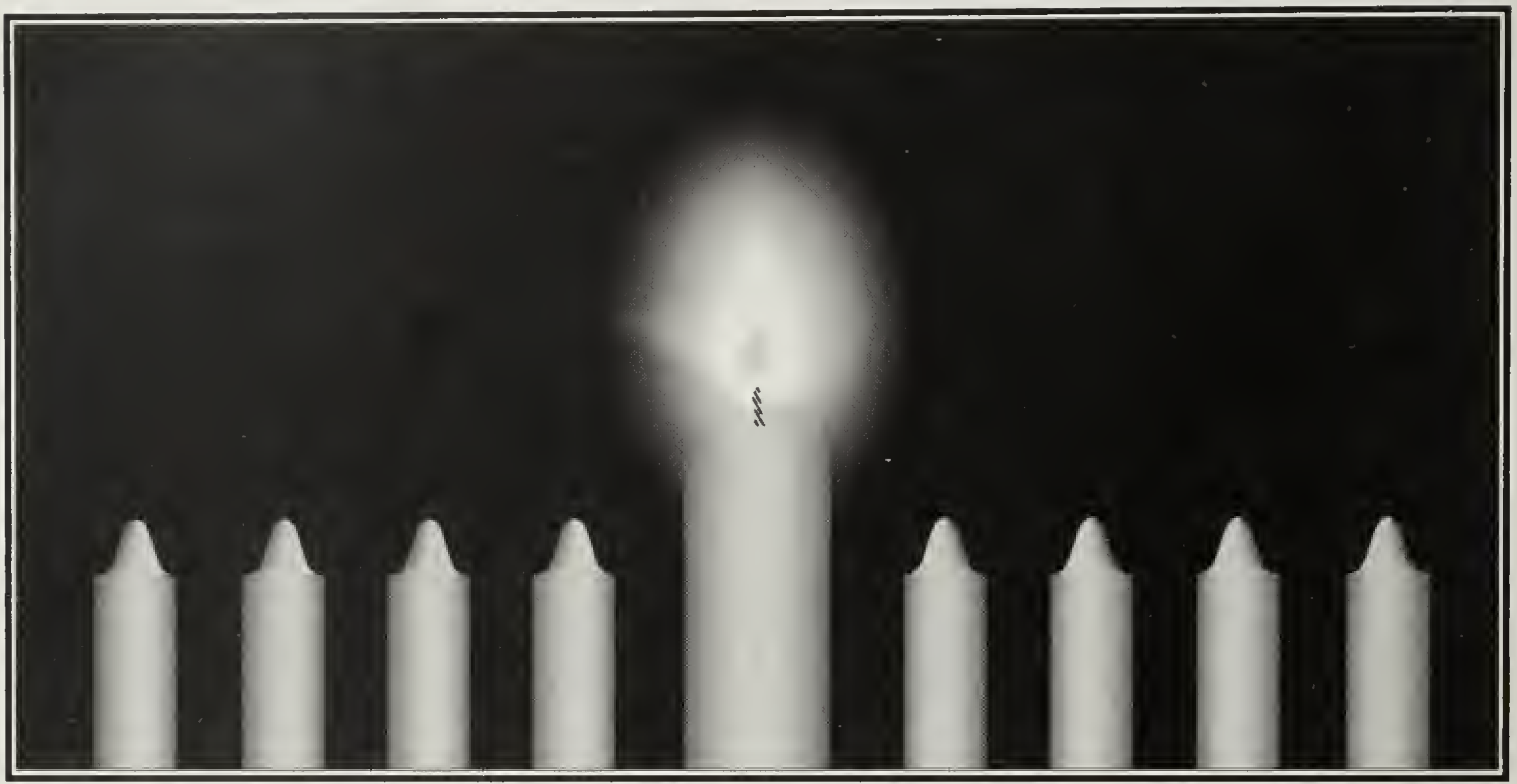

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Medical Newsletter	63
Merck, Sharp & Dohme	19, 20
MPMLC	IFC, 29
Nationwide Advertising	49
Palisades Pharmaceuticals	50
PC Medical	69
Pennock Hospital	24
Physician Service Group	1
PICOM	58
Prescott, Ball & Turben	59
Roche	55, 56
Shearson Lehman Bros.	28
St. Luke's	62
Trans Global Tours	64
US Air Force	46
Wayne State Alumni	61

PRESIDENT'S PAGE

A fond farewell

"The greatest pleasure of all...has been getting to know so many of you."

By Susan H. Adelman, MD

It does not seem possible that I am writing my last President's Page. It does not even seem believable that I have nearly completed my year of MSMS presidency. I am just getting used to squeezing elective surgical procedures around trips to Lansing, answering calls from reporters during office hours, and coming home each night to a pile of paper beneath my FAX machine. My husband is starting to enjoy driving me to county medical society meetings, and he says I seem to enjoy my speeches at these meetings more each time.

In fact, it turns out that the greatest pleasure of all in this job has been getting to know so many of you. I never realized that so many communities shared Wayne County's concerns about professional liability premiums and Medicaid as deeply as you do. I certainly never realized how many of my medical school classmates, fellow residents, and other colleagues, once from Detroit, are scattered to cities and towns throughout the state. What a delight it has been to renew old acquaintances!

Not surprisingly, it seems like some of my favorite projects are just now poised to begin. It is always that way. The Environmental Task Force has just started on its agenda. The Subcommittee on School Education for the Focus Group on Chemical Dependency is just identifying the needs across the state, and we have just made contact with the Michigan Bar Association, in preparation for working together on this project. The Subcommittee on Physician Education is just putting together a physician handbook on chemical dependency, with the expectation that this also will serve as a curriculum for physician education.

With the new governor, we finally have a real opportunity to make progress on professional liability, and I see that the sweet moments of success on this front remain to be enjoyed by my successors. On the other hand, Medicaid cuts have become a threat of previously unsuspected magnitude, thanks to our new governor. This is a fight I will be glad to hand over to others to suffer.

Modifying the new BCBSM Physician Agreement has occupied countless hours of my presidency as well as my year as president-elect. I am glad to report that the worst of the problems in that contract seem resolved, notably the despised original definition of medical necessity. It even looks like the remaining problems are all tracking well toward acceptable solutions. I wish I could say the same for the specter of impending legislation to introduce the Canadian health care system into Michigan. That problem is just beginning, though with the current state fiscal situation, this may well be an idea whose time both has come and has already left.

The issues raised by Doctor Kevorkian have dominated telephone calls from the press since the beginning of my presidency. Hastily drafted legislation was immediately introduced by Senator Dillingham and Representative Ciaramitaro, to ensure that Michigan does not become the suicide state. While this seems like a straw man, we have had to deal with the potential dangers that this initial legislation posed to the compassionate practice of medicine, and I think we have made a good start. We also were effective in keeping this bill from interfering with the passage of durable power of attorney legislation, which finally passed after 16 years of trying. MSMS will need to remain ever vigilant on the subject of assisted suicide, and we will need to refine and hone our ethical positions so that they remain consistent with the will of the public, as well as acceptable to the profession.

Changes in the licensure and discipline system have been an area in which we worked closely with the legislature over the last two years, and the package of bills we worked on will presumably pass this year. While there have been many disputes over the merits and demerits of the proposed new system, you can be sure that it would have been much worse if MSMS had not been on the job.

Nurse practitioners, nurse midwives, and other health care practitioners will continue to challenge physicians. We had our first bouts with Medicaid and BCBSM on these issues this year, and, if I do say so myself, we did not do badly. More confrontations will come, and we must continue to insist that our patients do not end up with two tiers of care, just so third party payers can save money by paying people other than doctors to perform medical services.

Many people made this year a joy, and many helped make it possible for me to successfully juggle MSMS and my practice. Key MSMS staff and MSMS physician leaders furnished superb support and advice. My predecessor, Bob Paxton, showed me the way. MSMS committee chairs carried the work of the organization forward. The MSMS Board and AMA Delegation all are extremely well informed, and they share in the leadership and decision making in ways that the membership ought to appreciate more. Certainly they do their share of work.

Thank you all for this year. My husband predicts that I will miss making speeches all the time. I certainly will miss the excuse to buy new clothes. Fortunately, I do not think I will have to miss the people, because I plan to remain very involved with MSMS well into the foreseeable future. ■

Doctor Adelman is MSMS president.

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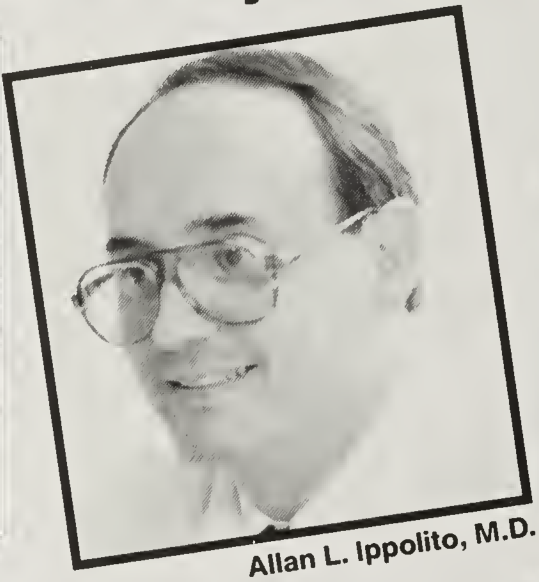

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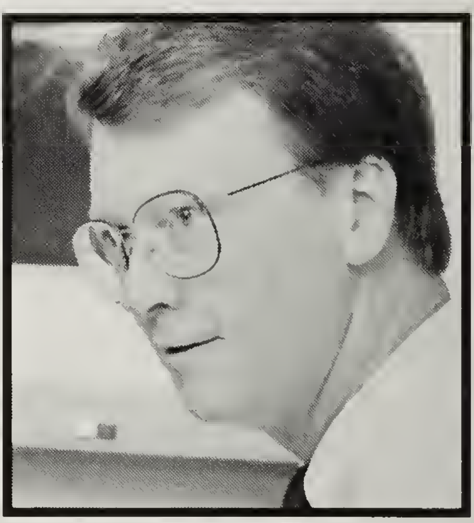

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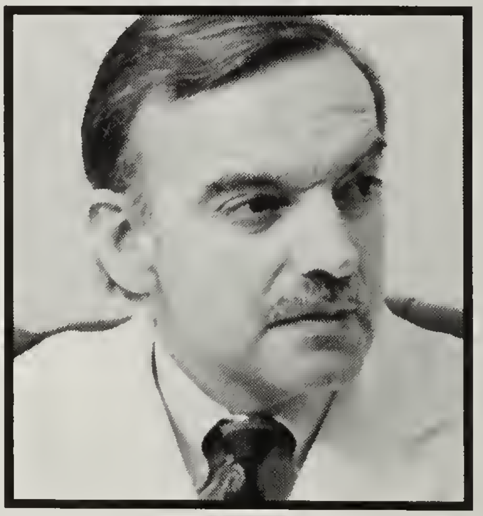

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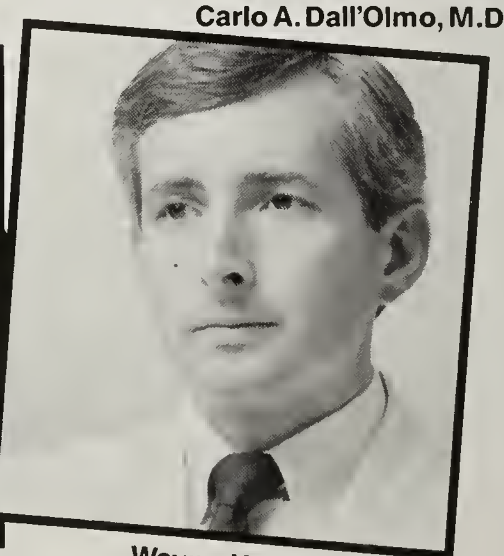

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MICHIGAN MEDICINE

16 COVER STORY

Medical liability reform in Michigan is the number one legislative priority of MSMS for 1991. Now, more then ever before, the climate for reform appears to be right. With the election of John Engler as Governor, the political climate looks promising, as he has indicated that medical liability reform is his top health policy priority. Legislation including tort reforms and an alternative to the traditional court system for settling medical liability claims has been proposed by Senator Dan DeGrow, R-Port Huron, and Senator John J.H. Schwarz, MD, R-Battle Creek. And, finally, the recent Hutzel Hospital decision, in which the plaintiff won a judgment of $19 million, has focused tremendous media attention on the liability problem in this state. MSMS efforts to promote liability reform are presented in this month's cover story. Following the cover story is a six-page brochure prepared by MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons, which examines the state's medical liability crisis in detail.

FEATURES

9 MSMS ON THE MOVE
This is the first of a new Michigan Medicine *feature on MSMS. Each month, this page will feature a "progress report" on MSMS activities in key areas of interest to MSMS members.*

27 MSMS MATERNAL AND CHILD HEALTH CONFERENCE
Photo highlights.

32 MSMS YOUNG PHYSICIANS SECTION
Photo highlights of the third annual meeting.

35 MSMS HOSPITAL MEDICAL STAFF SECTION
Photo highlights of the MSMS HMSS Seventh Assembly meeting.

37 MSMS SECTION FOR INTERNATIONAL MEDICAL GRADUATES
Photo highlights of the third annual meeting.

39 MEDICAL INQUIRER
This is the fourth in a series of factsheets prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. Readers are encouraged to tear it out and save it for handy reference.

43 MSMS BOARD OF DIRECTORS
Photo highlights of two guest speakers who recently addressed the Board at a meeting held at MSMS headquarters.

DEPARTMENTS

7 Letters
11 Newsfronts
12 Physicians in the News
44 Deaths
47 New Members
49 Meetings
50 Category I Courses
54 Classifieds
57 Advertising Index
58 President's Page
"We must match our desires with reality."
BY ROBERT D. BURTON, MD

In next month's issue of *Michigan Medicine*:
Annual Report on MSMS Activities
Cover illustration by: *Robert L. Brent.*

Page 16

Page 27

Page 37

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Letters from Our Readers

Lansing attorney reacts to article on assisted suicide

MSMS President Susan H. Adelman, MD, makes some interesting distinctions concerning her article, *"Physician-assisted suicide – A true dilemma"* in the March 1991 issue of *Michigan Medicine.* However, I feel Doctor Adelman further confuses this sensitive area by using the word "suicide" when a physician, with family approval, terminates life support systems. First off, suicide, according to Webster, is defined as "the act of killing oneself intentionally." Historically, ethicists as well as moral theologians have always felt that a person need only use ordinary means to preserve life. The withdrawal of life support systems is always categorized as *extraordinary* techniques to maintain life. That doesn't even come close to Webster's definition of suicide, which really doesn't apply in the situations delineated by Doctor Adelman.

It is not only the Hippocratic Oath, but also the natural law requires the preservation of life by ordinary means whether or not there is human suffering.

To me, a Kevorkian assisted suicide is clearly immoral and contrary to the Hippocratic Oath because the doctor deliberately and intentionally assisted the patient to commit suicide when *ordinary* means would have kept his patient living for years longer.

I would hope Michigan and all other clear thinking jurisdictions would never adopt the Dutch Medical Association guidelines for *euthanasia,* since such guideline is *contrary* to the natural law.

Thank you for allowing these comments.

Camille S. Abood
Abood, Abood & Rheaume, PC
Lansing

Editor's note: The following is a response from Doctor Adelman:

Mr. Abood correctly differentiates suicide from withdrawal of artificial life support, and I did not equate the two in my article. My comments were addressed to the broad spectrum of circumstances under which the physician must face ethical decisions about termination of life: 1) Conscious patients who can commit suicide but ask for help, 2) Conscious patients who wish to commit suicide but cannot because of incapacitation, 3) Unconscious patients, with or without living wills or durable power of attorney.

I further posited that if a patient is too incapacitated to commit suicide unassisted that he or she probably is too incapacitated to stay alive unassisted. This raises the argument that, in a sense, this patient is being kept alive by artificial means. Accepting this definition would add a new dimension to the argument.

Mr. Abood's other points are based on natural law, a concept which I find difficult to reference with any real precision.

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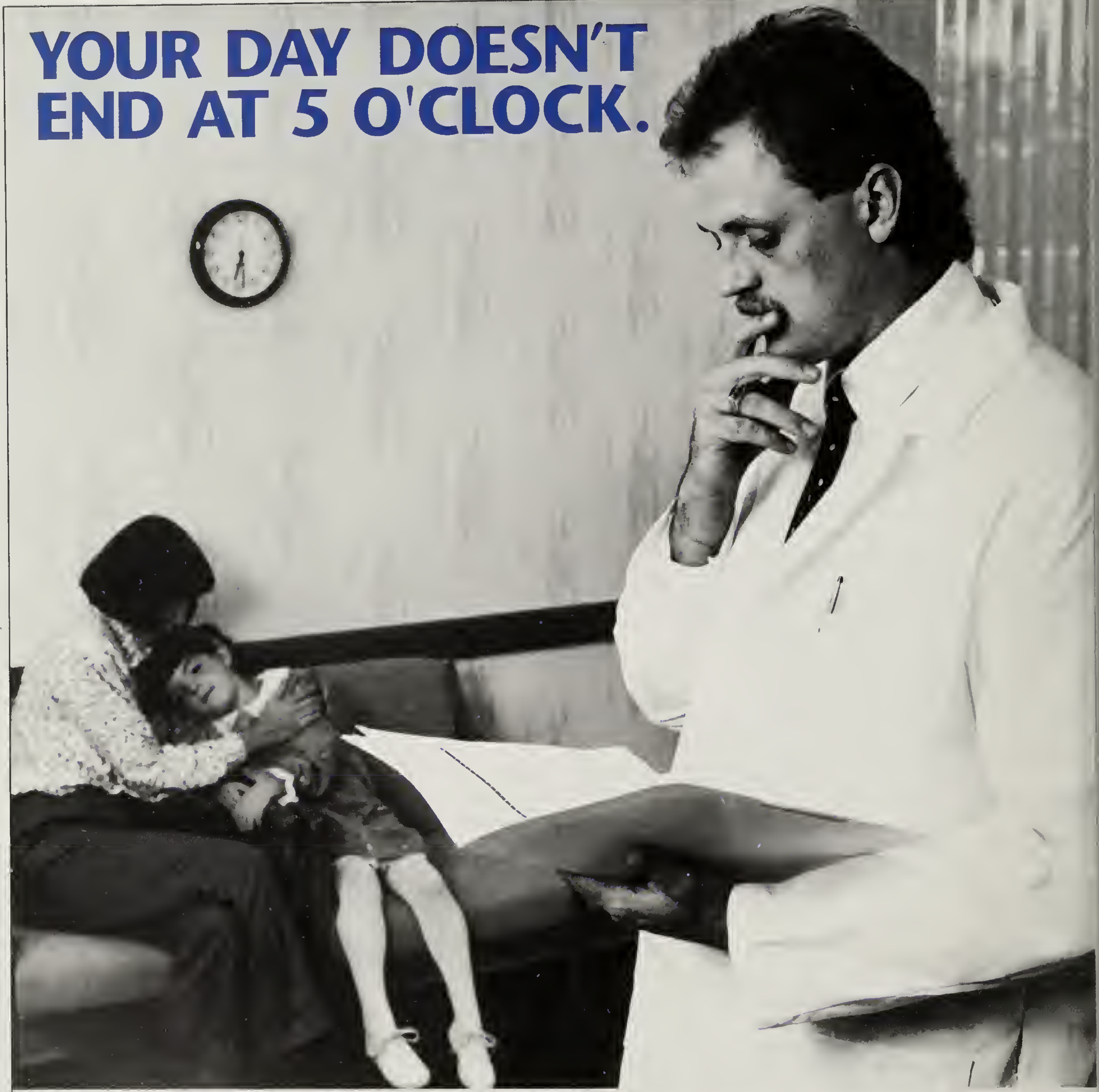

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MSMS On The Move

A monthly update of key MSMS activities

LIABILITY

A coalition comprised of MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons is shaping the course of liability reform through legislative introduction of the Michigan Alternative. The MSMS-developed proposal was introduced in the Michigan Legislature as Senate bills 248-249 by Sen. Dan DeGrow (R-Port Huron) and Sen. John Schwarz, MD (R-Battle Creek) in mid-April.

BLUE CROSS BLUE SHIELD OF MICHIGAN

As a direct result of recommendations from the 16-member Physician Contract Advisory Committee, which includes five MSMS representatives, BCBSM recently approved language changes in the new Physicians Participation Agreement. The changes restore determination of medical necessity to physicians. The new contract caused concern among physicians because, as initially written, it allowed BCBSM to determine medical necessity.

To ensure physicians are receiving improved service from Blue Cross Blue Shield of Michigan's (BCBSM) Provider Inquiry Department, MSMS surveyed 100 physician offices by phone about their experiences with BCBSM in late February and early March. MSMS found that there are still some problems with service, and will discuss the survey findings with BCBSM at the next meeting of the MSMS Liaison Committee with BCBSM.

MPRO OMBUDSMAN

MSMS has established an ombudsman to address concerns of members on Michigan Peer Review Organization (MPRO) letters of determination and quality. Call Tom Plasman, manager of the MSMS Hospital Medical Staff Section at (517) 337-1351.

PRACTICE MANAGEMENT

Ongoing physician education is an important tool in building a thriving medical practice. That's why MSMS has developed a number of seminars to help physicians sharpen their practice management skills. In April, MSMS offered "How to Run a More Profitable Practice." During May, physicians can learn the latest information about Medicare or how to do financial planning. In June, MSMS will instruct new physicians in how to get set up in medical practice. For more information, call the MSMS Office of Physician Education at (517) 337-1351.

SCOPE OF PRACTICE

MSMS is closely monitoring a bill in the Michigan Legislature, House Bill 4407, that would expand optometrists' scope of practice to allow them to treat certain eye ailments and to prescribe or administer therapeutic or ocular drugs. MSMS strongly opposes the bill, and testified against similar legislation in three legislative hearings last year.

BCBSM / MEDICARE REIMBURSEMENT OMBUDSMAN

Physicians who experience problems with BCBSM and Medicare reimbursements and audits can turn to MSMS for help. MSMS has appointed a reimbursement ombudsman, staff member Rose Heald, to assist physicians in resolving these problems. The ombudsman serves as liaison to BCBSM and Medicare; informs physicians of their rights and obligations; and monitors federal Medicare law and physician compliance requirements. Call Ms. Heald at (517) 337-1351 for more information.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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MEDICAL NEWSFRONTS

INDEX

Post-traumatic stress disorder affects many young adults 11

Sinai's ob/gyn program targets diabetic mothers 11

Liver tranplants for alcoholics 11

Study shows success of AIDS prevention/anti-smoking campaigns 12

Diabetes study underway at Harper, Grace hospitals 13

Henry Ford begins clinical trial of two new AIDS therapies 13

Kalamazoo hospitals cooperate on new kidney stone treatment 13

Sinai to begin trial of new drug for Parkinson's disease 13

National Prostate Cancer Detection Project receives grant 14

MDPH seeks patients exhibiting Lyme disease skin rash 14

Post-traumatic stress disorder affects many young adults

Before reaching age 30, up to 40 percent of young Americans experience a personal catastrophe, frequently involving violence, which could trigger lasting emotional scars, according to a new study from Henry Ford Hospital.

Called Health and Adjustment in Young Adults, the epidemiologic study of 1,007 adults between the ages of 21-30 found that 394 individuals had been exposed — at least once in their lifetime — to misfortunes which could trigger potentially devastating psychological consequences. Those traumatic incidents included being a victim of rape, assault, a serious car accident, natural disaster or fire; witnessing a murder or other violence; and receiving news about such catastrophes befalling a family member.

Of those who experienced such extraordinary events, roughly one-fourth suffered psychological harm, according to Naomi Breslau, PhD, of the Departments of Psychiatry and Biostatistics and Research Epidemiology at Henry Ford Hospital. Doctor Breslau is principal investigator of the study.

"Nine percent of young adults in our study were found to have suffered from post-traumatic stress disorder. That makes PTSD one of the most prevalent psychiatric disorders currently affecting young adults, ranking alongside substance abuse and depression in terms of frequency," said Doctor Breslau.

While PTSD was common, in 50 percent of those affected, the symptoms were present for only one year.

Participants in the study apparently were healthy adults, chosen randomly from the membership of the Health Alliance Plan, a health maintenance organization.

Sinai's ob/gyn program targets diabetic mothers

Diabetic mothers can receive one of the most intensive programs of prenatal care available through Sinai Hospital's Department of Obstetrics and Gynecology.

Known as "meticulous management," this care includes the most intensive program of education, nutritional and medical support for diabetic mothers currently available in metro Detroit.

Sinai's program for diabetic mothers includes close contact between the mother's obstetrician, members of Sinai's Division of Maternal-Fetal Medicine and primary care physician to monitor and regulate insulin intake.

Through Sinai's program, mothers receive daily phone calls to make certain they stick to a regimented diet and control their insulin dosage. Each mother works closely with a Sinai nutritionist and receives a complete training in meal planning and the effects of diet on their diabetic condition. Mothers are also taught by Sinai doctors and nurses how to monitor their blood sugar levels.

More than 500 babies have been delivered through this program over the past six years.

Liver transplants for alcoholics?

Should alcoholics, who through years of drinking, have destroyed their livers, be eligible for liver transplants?

This question, which haunts physicians, nurses and other health care professionals, is answered "yes" in a recent *Journal of the American Medical Association (JAMA)* article in which one of the principal authors is a Michigan State University medical ethicist.

"There is no good moral or medical reason for categorically precluding alcoholics for liver transplantation," the medical ethicists wrote in "Alcoholics and Liver Transplantation" which appeared in the March 13, 1991, issue of *JAMA*.

The article was written by members of the Ethics and Social Impact Committee of the Transplant and Health Policy Center. The principal authors were Doctor Martin Benjamin, MSU professor of philosophy and committee chairperson, and Doctor Carl Cohen of the University of Michigan.

Also appearing in that same issue is an article taking the opposite point of view. Written by Doctor Alvin H. Moss of West Virginia University and Doctor Mark Siegler of the University of Chicago. It argues that people should be held accountable for their actions and those whose liver disease was the result of alcoholism "should be given a lower priority for liver transplantation" than non-alcoholics.

Much of the dispute centers on how one views access to medical care, said Benjamin. Whether alcoholism is a moral failing or chronic disease is irrelevant.

"We could rightly preclude alcoholics from transplantation only if we assume that qualification for a new organ requires some level of moral virtue, or is canceled by some level of moral vice," the article state. "But there is absolutely no agreement upon what constitutes moral virtue and vice and what rewards and penalties they deserve."

The article said personal conduct does not disqualify one from receiving medical attention, noting that auto accident victims are treated even if they weren't wearing seat belts and smokers are regularly treated for heart disease.

Another argument against liver transplants for alcoholics is the alcoholic is a "bad risk" and is unlikely to benefit from an organ which is in such short supply.

However, the article noted

Continued on page 12

Continued from previous page

that recent studies show survival rates for both carefully selected alcoholics and non-alcoholics are about even. The studies also show that very few alcoholics return to drinking following a liver transplant.

"Liver transplantation, it would appear, can be a very sobering experience," the article noted.

The article said that alcoholism must be one of the factors taken into account when screening and selecting transplant candidates. However, it's argued that alcoholism must not be the sole criterion.

"The central question is whether patients are sick enough to need a new organ and enjoy a high enough probability of benefiting from the receipt of this limited resource," it said. "At this stage, the criteria should be non-comparative."

The article noted that while no excuses can be made for behavior such as drunken driving and family neglect and abuse, it is wrong to generalize.

"Not all alcoholics are morally irresponsible, vicious or neglectful drunks," the story said.

Study shows success of AIDS prevention/ anti-smoking campaigns

Results from an evaluation of the Michigan Department of Public Health (MDPH) AIDS prevention and anti-smoking advertising campaigns have been released.

The media campaigns are part of a statewide effort to improve knowledge, attitudes and behavior related to AIDS and tobacco use.

Study findings show that the campaigns, created by Brogan & Partners Advertising of Southfield, have had two to five times higher levels of exposure than typically achieved in national advertising campaigns and have made a significant contribution to information-seeking and risk reduction behaviors by the target populations.

"We are gratified by the effectiveness of these campaigns. They are an essential part of our overall efforts to prevent AIDS and smoking," said Vernice Davis-Anthony, director of the state health department.

The campaign evaluation, conducted by Moore & Associates, Inc., of Southfield, shows that:

- 45 percent of Michigan residents, ages 10-54, can describe elements of the 1989 MDPH anti-smoking campaign; 17 percent claim awareness of the smoking hotline, established in June 1989;
- 33 percent recall AIDS advertising which can be uniquely identified as part of the 1989 MDPH campaign; 57 percent claim awareness of the AIDS hotline which has been publicized since January 1988;
- Approximately three-quarters of these respondents feel the advertising is useful and effective;
- The campaign's target audience groups are among those most likely to recall the ads.
- There is a strong and direct relationship between the media campaign and hotline utilization resulting in increased calls to the hotline when television ads are shown.
- AIDS risk avoidance among adolescents is associated with campaign exposure as is increased knowledge about routes of HIV transmission among both Michigan adults and adolescents.
- There has been a substantial increase in

Continued on page 13

Physicians in the News

Robert H. Burke, DDS, MS, MD, Ann Arbor, is the newly-elected president of the American College of Oral and Maxillofacial Surgeons for the term 1991-1993. He is medical director of the Michigan Center for Cosmetic Surgery and also maintains a private practice in cosmetic surgery with special emphasis on maxillofacial reconstruction.

Kevin M. Fickenscher, MD, assistant dean, Michigan State University College of Human Medicine, Kalamazoo campus, has been named a 1991 Emerging Leader in Health Care. The award, given by Healthcare Forum, a national health industry group based in San Francisco, and Korn/Ferry, the nation's largest health care personnel recruiting firm, is presented annually to only six people nationwide.

Robert N. Hensinger, MD, Ann Arbor, is newly-elected first vice president of the American Academy of Orthopaedic Surgeons. Doctor Hensinger is professor, Department of Surgery, University of Michigan, and chief, Division of Pediatric Orthopaedics at Mott Children's Hospital, Ann Arbor.

William R. Keye, Jr., MD, director, Division of Reproductive Endocrinology and Infertility, William Beaumont Hospital, has been awarded the Dalton Society Medal for 1990 for his work in the area of premenstrual syndrome (PMS). The Dalton Society is a professional organization composed of scientists, nurses and physicians from around the world who have a special interest and expertise in PMS. The organization was founded in 1985 and was named to honor Doctor Katherina Dalton, a British physician who has pioneered research of premenstrual syndrome for the last 35 years.

E. Dennis Lyne, MD, director of Multidisciplinary Clinic, and head of the Division of Pediatric Orthopaedic Surgery, Henry Ford Hospital, is the newly-appointed director of the Orthopaedic Surgery Residency Program at Michigan State University, Kalamazoo Center for Medical Studies. Doctor Lyne has held academic medical training appointments in Orthopaedic Surgery at Johns Hopkins Hospital, Baltimore; Chelsea Naval Hospital, Boston, the Northwestern School of Medicine, Chicago, and the University of Michigan.

W. Patrick Mazier, MD, president of Ferguson Clinic, Grand Rapids, has been selected by *Good Housekeeping* magazine as one of the 400 Best Doctors in America. Doctor Mazier also runs the largest colon-rectal residency program in the United States, which has trained more surgeons in the specialty than any other institution.

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requests for HIV risk reduction counseling and HIV antibody testing at MDPH-supported facilities since campaign initiation with a quarter of clients citing campaign media sources as their stimulus for seeking services.

- Significant numbers of callers to the smoking hotline indicate smoking cessation activity after receiving information and self-help materials.

"The results of this evaluation are significantly better than those we usually see in research concerned with media effectiveness," said JoAnn Rossi of Moore & Associates, Inc.

Marcie Brogan, Brogan & Partners president said, "The extent to which Michigan citizens recall our ads and their positive responses exceeded our expectations of the campaigns' impact. Our agency is proud to be a part of a program to help reduce health risks for AIDS and other chronic diseases."

The MDPH campaigns are part of a five-year health promotion program with advertising messages related to prevention of AIDS and other major chronic diseases. In 1989, the state launched its first-year multi-media AIDS prevention campaign. The success of that effort led to the extension of the AIDS campaign and initiation of a health promotion campaign with smoking, the state's number one health risk, as the first focus.

Future campaigns may focus on violence reduction and other important health issues, Anthony said.

Diabetes study underway at Harper, Grace hospitals

Harper and Grace hospitals, together with the Wayne State University School of Medicine, are looking for individuals with diabetes for a four-year study involving the use of Tolrestat, a medication believed to either prevent or delay the onset of kidney disease related to diabetes. The principal investigator for the study is George Grunberger, MD, director of the diabetes program at Harper and Grace hospitals.

To be eligible individuals should meet the following criteria:

- Have Type I (juvenile onset) diabetes
- Be a male or female between the ages of 18 and 50 (women must be sterile or post-menopause)
- Have no serious medical complications including kidney disease

All medical care and supplies associated with the study are provided free of charge. For additional information, contact Melissa Baker, RN, clinical research coordinator at (313) 745-1783.

Henry Ford begins clinical trial of two new AIDS therapies

Henry Ford Hospital is seeking volunteers to participate in a nationwide study of two experimental AIDS therapies which doctors hope will help many patients live years longer.

Although the therapies don't promise a cure to those infected with human immunodeficiency virus (HIV), researchers hope the antiviral drugs will slow HIV disease and prolong life, according to Louis D. Saravolatz, MD, division head Infectious Diseases and Hospital Epidemiology, Henry Ford Hospital, and principal investigator for the study.

The two therapies under investigation, ddI (dideoxyinosine) and ddC (dideoxycytidine), are being considered as a possible alternative to AZT. Although AZT has stretched life expectancies for many HIV-infected patients, alternative therapies are clinically needed because many people either can't take AZT or have to stop taking it due to side effects.

"It's always very difficult to tell a patient their medication is not working on them. It's even more difficult to tell them it's not working and that there's nothing else you can offer them," said Doctor Saravolatz. "For those who can't take AZT, these new therapies are their only hope."

"When we started using AZT, patients went from an average nine-month survival to two years," says Doctor Saravolatz. "With ddI and ddC maybe we'll be able to stretch that to three or four years."

The purpose of the study is to compare the effectiveness of ddI and ddC in slowing HIV disease and to catalog the frequency and severity of side effects to determine how well each drug is tolerated.

The two-year study is being conducted at 18 sites in 14 cities nationwide as part of the National Institute of Allergy and Infectious Diseases' Community Programs for Clinical Research on AIDS (CPCRA). Altogether, 400 persons infected with HIV are expected to enroll.

Candidates for the study must be 18 years of age or older and have either failed treatment with AZT or be intolerant of it. They must also have T4 cells counts of 300 or less or have an AIDS-defining illness. Patients with a previous history of treatment with ddI or ddC, pancreatitis, peripheral neuropathy, uncontrolled seizures, excessive alcohol use or heart disease are excluded from the study.

Participants in the study will be randomly assigned to take either ddI or ddC, provided free by the pharmaceutical companies. Patients will be followed in regular clinical visits throughout the course of the two-year trial. Henry Ford Hospital will be enrolling patients into the study for the next 12 months.

For more information about the study, or any other AIDS studies planned through CPCRA, call (313) 876-7664.

Kalamazoo hospitals cooperate on new kidney stone treatment

Bronson Methodist Hospital and Borgess Medical Center are joining together to bring a mobile lithotripter to Kalamazoo. Currently, lithotripsy is available in west Michigan only in Grand Rapids. "Having this technology in the community will be of tremendous convenience to area patients," said Kalamazoo urologist, Lee Underwood, MD. "It will allow doctors to treat patients with renal and ureteral stones in a much less invasive manner."

The two hospitals will achieve additional cost savings as the new service will be a mobile unit, shared jointly by Bronson, Borgess and four other hospitals in Michigan. Also, since the mobile unit is a virtually self-contained medical laboratory, it can be used at both Borgess and Bronson, with minimal additional construction costs.

Kalamazoo urologists began using the lithotripter at Bronson in April. The service will be available at Borgess this summer.

Sinai to begin trial of new drug for Parkinson's disease

The Clinical Neuroscience Program at Sinai Hospital will be among 14 medical centers throughout the United States beginning an outpatient trial evaluating a new Parkinson's disease medication.

Directing the study at Sinai is Peter A. LeWitt, MD, a nationally recognized expert in the treatment of Parkinson's disease and director of Sinai's

Continued on page 14

Continued from page 11

Clinical Neuroscience Program.

The new drug will be tested for its potential value in several applications, including slowing the progression of Parkinson's disease and enhancing the therapeutic value of several available medications.

This drug, currently termed Ro 19-6327, is under development by Hoffman-La Roche of Nutley, New Jersey. The multi-center study will evaluate its safety, tolerability, and effect on clinical symptoms of Parkinson's disease.

This study is directed at persons affected with mild symptoms of Parkinson's disease.

There is no cost to patients who participate in this study. Patients can receive evaluations for Parkinson's disease and further information regarding the study by contacting the Clinical Neuroscience Program, Sinai Hospital at (313) 493-5354.

National Prostate Cancer Detection Project receives grant

The National Prostate Cancer Detection Project (NPCDP), headquartered at Catherine McAuley Health System, Ann Arbor, has received over $76,000 in grants from sources nationwide.

The NPCDP is an international effort which researches early detection methods for prostate cancer. It involves 13 medical centers in the United States and Canada and a multi-disciplinary team of physicians. The project is co-directed by Fred Lee, MD, a radiologist at CHMS.

MDPH seeks patients exhibiting Lyme disease skin rash

Epidemiologists from the Disease Surveillance Section at the Michigan Department of Public Health (MDPH) would like to see and interview patients with physician-diagnosed Lyme disease currently exhibiting the typical Erythema Migrans skin rash who were likely to have been exposed to Lyme disease in the lower peninsula of Michigan. They request that physicians report such patients by telephone to their local health department. On receiving the relay of your report from local public health authorities, an MDPH epidemiologist will contact the physician by phone to collect some baseline information and to make sure it is okay to visit the patient.

MDPH will then take a history of your patient's illness including a thorough history of any potential exposures to ticks in the month prior to onset of illness. If the physician requests it, for adult patients, a blood specimen will be collected for testing in the MDPH diagnostic microbiology laboratories.

The last step in the investigation of your patient's illness will be to conduct a thorough environmental search for ticks and rodent reservoir species in the area where the patient was most likely to have been exposed to ticks carrying Lyme disease.

A copy of the report, including the results of any blood work done, will be forwarded to the attending physician and the local health department upon completion. ■

Michigan State Medical Society

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LIABILITY REFORM IN MICHIGAN

THE CLIMATE IS RIGHT

By Ralph D. Ward

Medical liability reform in Michigan is the number one legislative priority of MSMS for 1991. Now, more than ever before, the climate for reform appears to be right. With the election of John Engler as Governor, the political environment looks promising, as he has indicated that medical liability reform is his top health policy priority. Legislation including tort reforms and an alternative to the traditional court system for settling medical liability claims has been proposed by Senator Dan DeGrow, R-Port Huron, and Senator John J.H. Schwarz, MD, R-Battle Creek. And, finally, the recent Hutzel Hospital decision, in which the plaintiff won a judgment of $19 million, has focused tremendous media attention on the liability problem in this state. MSMS efforts to promote liability reform are presented on the following four pages. Following those four pages is a six-page brochure prepared by MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons, which examines the state's medical liability crisis in detail. ☞

The time is right for medical liability reform in Michigan. So says a growing body of the state's health care opinion leaders, and supporters of the initiative believe they have the legislation and the political atmosphere to do it.

The support for liability change comes five years after passage of the state's last major liability reform package in 1986. There is little argument that those reforms have, in some aspects, succeeded, reducing annual liability insurance rate increases from the stratospheric double digits five years ago to the low single digits today. The number of liability claims made likewise fell — at least temporarily. But with the passage of five years, dark hints that Michigan's medical liability problem was only delayed, not solved, have grown increasingly hard to ignore.

Figures compiled by the MSMS and the Michigan Physicians Mutual Liability Company indicate that the number of liability lawsuits against MPMLC insurers peaked in 1986 at 1,330. While the number declined steadily to 811 in 1989, suits shot back up to 950 in 1990. Perhaps more disturbing are the figures for average payment per claim. Except for a brief downtick during the rush of suits filed in 1987 to beat the new liability reforms, both MPMLC and Physician's Insurance Company of Michigan show an uninterrupted climb in the average payment per claim through 1990. Average PICOM payout shot up 87 percent between 1985 and 1990, brushing aside any moderation from the reforms.

According to Thomas E. Stone, MD, chairman of the MSMS Task Force on Medical Liability, his group has found "the 1986 changes didn't reform the system. We knew they wouldn't, but we had to give them a fair chance." Many of the continuing flaws in the state's liability system, according to Doctor Stone and other observers, stem from compromises needed to pass the original 1986 legislation. A strong cap on damages was originally sought, but a number of weakening exemptions were included through the efforts of reform opponents. "The biggest need was for an economic cap on damages" says Doctor Stone. "But with so many exemptions added, the cap is now virtually meaningless."

The damage to the state's economy and health care system caused by runaway liability has also run on unabated. Defensive medicine cost America almost $14 billion in 1987, and metro insurance costs have left Detroit, a city of over one million, with only 12 obstetricians in private practice. The recent Hutzel Hospital case, with a judgement of $19.7 million on a questionable "bad baby" delivery, has brought attention to the ways huge liability payments ultimately harm health care for us all. Says Doctor Stone: "In the Hutzel case, the attorney fees on both sides alone would total enough to give prenatal care to 30,000 Medicaid recipients." Liability repercussions are finally making medical care in Michigan so expensive and unobtainable that state politicians are starting to feel the heat from constituents. Says Senator Dan DeGrow (R-Port Huron): "Among the public, the main concern is that it's hard to attract physicians, especially to rural areas."

The result of these pressures has been a new legislative initiative for liability reform in 1991. Senator DeGrow introduced Senate Bills 248-249, known as The Michigan Alternative, in April. Both offer real hope for liability relief. (See summary of the bills below.) "The key part is non-economic caps" says Sen. DeGrow. As now written, the bills would limit non-economic damages to $225,000 and end the exemptions for death, reproductive injury, and loss of vital bodily function. Attorney fees would be limited, and expert witness qualifications would be tightened. There would be a stricter statute of limitations, and a 180-day notification would be required before suit could be filed. Signing on for the renewed reform effort are the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians.

So the stage is set, in 1991, for another, perhaps more successful, attempt to overhaul Michigan's liability laws. Why now? Many feel that five years have given the 1986 package adequate time to prove — or more accurately, disprove — itself. The most immediate impetus is the state's new governor. John Engler has been outspoken in supporting medical reform in Michigan, and observers are optimistic that he'll be receptive to new legislation. At the March 13 Michigan Hospital Association "Day at the Capital" program the Governor spoke in detail about the need for liability reform, although avoiding any direct endorsement of legislation. Points mentioned were a need to limit non-economic

The Michigan Alternative – Senate Bills 248-249

Legislation including tort reforms and an alternative to the traditional court system for settling medical liability claims has been proposed by Senator Dan DeGrow, R-Port Huron, and Senator John J.H. Schwarz, MD, R-Battle Creek. This legislation is supported by the coalition of the Michigan State Medical Society, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons.

Under this proposed legislation, patients may bring suit either through the traditional, costly, time-consuming court system or they may choose a treamlined system to resolve the dispute quicker with more of the settlement money going to the patient. Specifically, the proposed legislatin includes:

- *an alternative dispute resolution system*
- *a limit of $225,000 on non-economic damages, such as pain and suffering*
- *elimination of death, injury to the reproductive system and loss of vital bodily function as exceptions to the limit on non-economic damages*
- *a limit of $1.5 million for economic damages, such as medical costs and lost income*
- *sliding scale for attorney fees*
- *stricter statute of limitations*
- *stricter criteria for qualification as an expert witness*
- *180 day notice before a medical liability suit can be filed*
- *elimination of the lost chance doctrine*

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Further ammunition in the liability battle was provided by the release of data by former Governor Blanchard's factfinder Professor Robben Fleming. The Fleming figures showed conclusively that Michigan physicians pay very high liability insurance premiums. And the Hutzel Hospital case was the type of attention-grabbing outrage that galvanizes opinion as to the seriousness of a problem.

What is the political future for liability reform? The battle for reform will surely provoke the same strong passions as last time. "I believe the Senate will be behind us" says Doctor Stone. "But we'll have problems in the House." Sen. DeGrow, a supporter of the reforms, points to support from Senator John Schwarz and Senator William Van Regenmorter, chairman of the Senate Judiciary Committee. However, House Judiciary Chairman Perry Bullard is a likely opponent of reform.

Key opposition will, again, be Michigan's trial lawyers. "It looks like the trial lawyers will offer strong opposition," says Doctor Stone. "From the beginning, they have been very focused on this issue. It appears that they are completely negative, wanting no change whatsoever. They seem to believe the current system is perfectly fine."

The negotiation process began long before introduction of the bills, and continues. At a January meeting, Doctor Stones' Liability Task Force outlined their "shopping list" for reform legislation, to Sen. DeGrow. "We told him the most pressing needs were for a cap on non-economic damages, for a statute of limitations, and presuit notification requirements, and changes in the contingency fee structure are in the DeGrow bill.

Those supporting the reform liability package are continually optimistic of success this term, though realistic about the battles ahead. The deterioration of Michigan's liability system will stiffen their resolve, and weigh against too much compromise. "There isn't much room to maneuver" says Doctor Stone. "If our solutions are not carefully structured, the situation will become worse instead of better."

Ralph Ward is a Lansing-based freelance writer.

MSMS-sponsored radio spots target medical liability

MSMS and county medical societies statewide ran radio spots in March on the medical liability crisis in Michigan. Three southeast counties ran similar ads to increase public awareness about the problem. MSMS initiated efforts to expand the program statewide, combining county contributions with MSMS funds to pay for the spots. One radio spot briefly listed facts about the malpractice crisis, including the fact that Michigan doctors pay the highest malpractice premiums in the Great Lakes region. The other spot focused on the cost of the malpractice crisis and what this is doing to health care services (See sample script at right). The spots ran in major radio markets March 18 through March 22, including WFMK in Lansing; WOOD in Grand Rapids; WFDF in Flint; WHNN in Saginaw; WJPD/WDMJ in Marquette; WHFB in St. Joseph/Benton Harbor; and WZRK in Hancock.

Radio Ad No. 1

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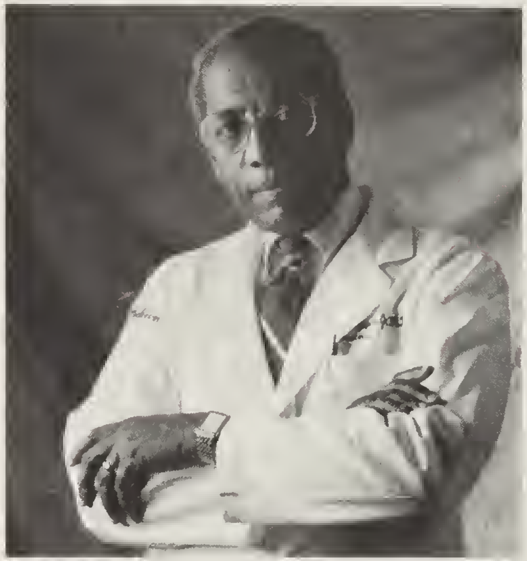

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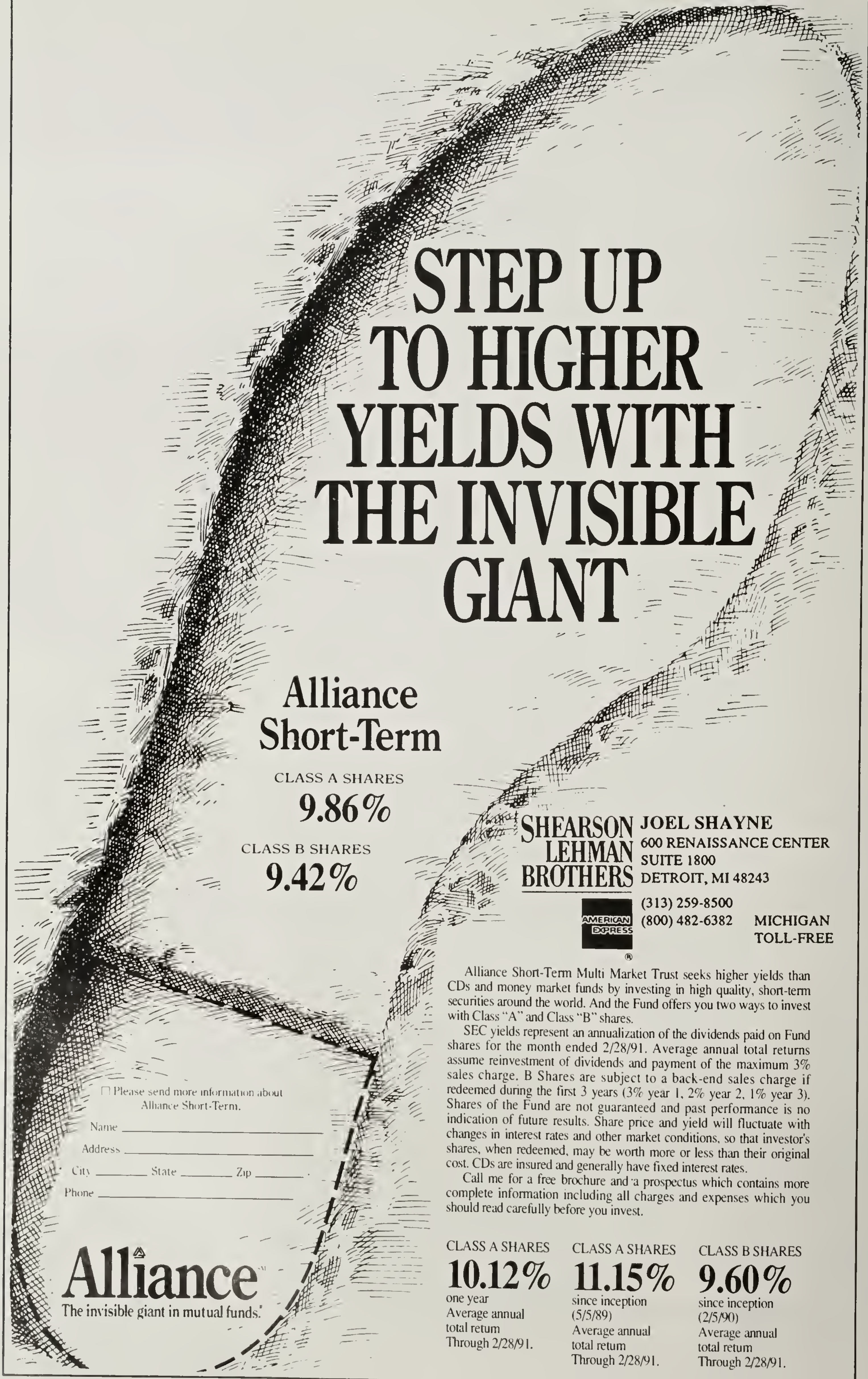

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Cover Story

MSMS co-sponsors session on liability and leadership

Plenty of advice was offered at a session on "Lansing, Liability and Leadership," cosponsored by MSMS and the Michigan Physicians Mutual Liability Company, held April 10 in East Lansing.

Be strong, be tough and don't give up too early on medical liability reform, was the advice of William Sederburg, PhD, vice president for public policy, Public Sector Consultants, a Lansing think-tank. Spend money wisely, be committed and word hard through focused, cooperative activities, were the recommendations of Gerald Faverman, PhD, Public Sector Consultants chairman. Agree as a community to seek specific reforms, to say the same things, to expand your coalition and to make reform a political issue, advised Dennis Schornack, senior policy advisor to Governor Engler.

The meeting drew 75 leaders from the liability reform coalition of MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons. Inside information and advice were abundant as the group discussed the coalition workplan for liability reform, new medical liability reform legislation, the liability climate's effect upon the Michigan Physicians Mutual Liability Company, the state budget-cutting, the Engler administration and health care policy.

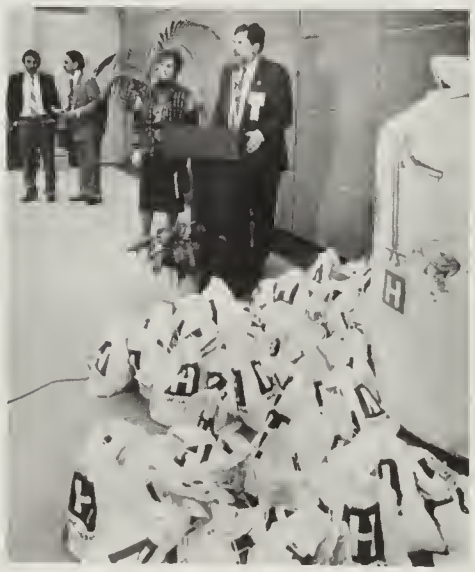
Craig Ruff, president and senior consultant for public policy with Public Sector Consultants, described Michigan as a state with a polarized electorate, an anxious economy, a paralyzed political system and old politicians in new roles. Sederberg characterized Gov. Engler as a "chess player;" a rational, rather than gut-level decisionmaker, a leader who enjoys conflict rather than taking the traditional political role of consensus-building.

Audience members interrupted Schornack's talk with applause as he explained that Gov. Engler's health care priorities are, "quite simply, liability reform, liability reform, and liability reform." The governor has a special pen set aside for signing medical liability reform legislation, he revealed. He explained the state is experiencing reduced access to care, higher expenditures for care, and an ineffective and costly dispute resolution system. "It's darn hard to find anybody in Michigan benefiting from the status quo," he continued.

Sen Dan DeGrow (R-Port Huron), sponsor of new legislation offering a "Michigan Alternative" to the current liability situation, counseled the group that the key to public acceptance of the alternative is "to explain what it means to do nothing about medical liability. If we do noting, it means longer waits for health care and longer distances to travel for it." Access to care is the key message when you talk to the public, he said.

Other speakers included Thomas E. Stone, MD, chairman of the MSMS Task Force on Professional Liability, and Thomas C. Payne, MD, chairman of the MSMS/MPMLC Risk Management Committee.

MSMS participates in news conference on liability reform



MSMS, the Michigan Hospital Association (MHA) and the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS) held a news conference in Lansing March 13 to brief the news media on the need for liability reform in Michigan. Pictured here are, from left to right: Sen. Dan DeGrow (R-Port Huron); MAOPS President Peter B. Ajluni, DO; MSMS President Susan H. Adelman, MD; and MHA President Spencer C. Johnson. Following the news conference, MSMS, MHA and MAOPS delivered more than 350 bags of telegrams calling for liability reform to legislators at the State Capitol. The telegrams were from physicians and patients around the state.

LANSING
LIABILITY
AND

Dennis Schornack, senior policy advisor to Governor John Engler, discussed the Governor's policy ambitions. Audience members interrupted his presentation with applause as he explained that Gov. Engler's health care priorities are, "quite simply, liability reform, liability reform, and liability reform."

Senator Dan DeGrow (R-Port Huron), was one of several speakers at the April 10 session on, "Lansing, Liability and Leadership: An Update," held in East Lansing. The topic of his presentation was, "The Michigan Alternative: The Medical Liability Determination Act."

D. SCH
C. RUFF
W. SEDERBURG
R. KLEIN

The "Lansing, Liability and Leadership" session featured a dozen speakers. Three of the speakers (shown above) were representatives of Public Sector Consultants, a Lansing think-tank. Pictured left to right are: William Sederburg, who spoke on "John Engler's Impact on the Executive Office" ; Robert Kleine, who spoke on "Budget Cutting and It's Impact on Health Care" ; and Gerald Faverman, who offered closing comments.

Mitchell A. Rinek, MD, chairman of the MSMS Committee on State Legislation and Regulations, (shown standing) was one of 75 leaders from the liability reform coalition of MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons who attended the meeting.

Photos by Pattrick Yockey

William Sederburg, vice president for public policy, Public Sector Consultants, Lansing, told session attendees to be strong, be tough and don't give up too early on medical liability reform.

Anthony Southall, MD, rose to his feet to question one of the session's speakers.

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The 20th Annual MSMS Conference on Maternal and Child Health, held March 13-14 at the Ritz Carlton Dearborn, drew approximately 350 physicians, nurses and other health care professionals. The theme of the conference, which featured scientific courses and exhibits, was "Maternal/Child Health: A Critical Balance."

Richard Schwartz, MD, president-elect of the American College of Obstetricians and Gynecologists, spoke on "The Future in Maternal/ Child Care Begins Now."

Fred R. Severyn, MD, vice president and corporate medical director, Blue Cross and Blue Shield of Michigan, discussed "Health Care Insurance Carrier/BCBSM" during the Wednesday morning general session.

In addition to the scientific sessions on pediatrics and obstetrics, the 30th Annual MSMS Conference on Maternal and Child Health featured two half-day general sessions, luncheon speakers, scientific poster presentations and exhibits.

Robert P. Lorenz, MD, (left) chairman of the MSMS Committee on Maternal and Perinatal Health, took a moment to chat with conference speaker James R. Scott, MD, (right) professor and chairman, Department of Obstetrics and Gynecology, University of Utah School of Medicine, Salt Lake City, who spoke on "Routine Vaginal Birth After Cesarean," and Soloman Rosenblatt, MD, (center) of Beaumont Hospital, Royal Oak.

Photos by Ron Ponkey

Continued on page 29

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Announcement

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Seventeenth Assembly Meeting
June 20 - 24, 1991

Medical staffs from across the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly Meeting June 20 - 24, 1991 at the Chicago Marriott Hotel in Chicago, Illinois.

The HMSS Assembly provides medical staffs with a unique opportunity to discuss and participate in the policymaking process of the AMA. In addition to the Assembly Meeting, an educational program on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Practice Parameters will be presented. An information exchange will also be held on PRO and Managed Care Review.

If you are unable to participate in the Chicago Meeting, we encourage you to call us with the name of your HMSS Representative.

For further information about the AMA-HMSS, please call (312) 464-4754 or 464-4761.

MATERNAL & CHILD HEALTH MEETING HIGHLIGHTS

Continued from page 27

Above: *Don Snell, executive vice president and chief operating officer, Hutzel Hospital, Detroit, discussed the "Impact of Reimbursement on Delivery of Services," at the Wednesday morning general session.* **Above right:** *Steven M. Donn, MD, professor, Department of Pediatrics/Section of Newborn Services, and medical director, Holden Neonatal Intensive Care Unit, U-M Medical Center, conducted two pediatric sessions: one on "Respiratory Support in Neonatalogy, 1991;" the other on "Neonatal Seizures: Diagnosis and Treatment."* **Right:** *Conference goers had the option of attending one of six luncheon presentations on Thursday. Topics ranged from "Drugs, Tabacco and Firearms," to "Pediatric AIDS."*

R SCHWARTZ
F SEVERYN
D SNELL
D GAGNON

Four speakers were featured during the Wednesday morning general session. They were (l to r): Richard Schwartz, MD, president-elect of ACOG, who spoke on "The Future in Maternal/Child Care Begins Now"; Fred R. Severyn, MD, vice president and corporate medical director, Blue Cross Blue Shield of Michigan, who spoke on "Health Care Insurance Carrier/BCBSM"; Don Snell, executive vice president and chief operating officer, Hutzel Hospital, Detroit, who spoke on the "Impact of Reimbursement on Delivery of Services" and David Gagnon, MPH, executive director of the National Perinatal Information Center, Providence, Rhode Island, who spoke on "Prenatal Care: The Relationship to Cost of Neonatal Care."

Approximately 22 organizations exhibited at the conference. Representatives of the exhibiting firms were on hand throughout the two-day event to offer samples of their products, informational brochures and to answer questions.

Continued on next page

MATERNAL & CHILD HEALTH MEETING HIGHLIGHTS

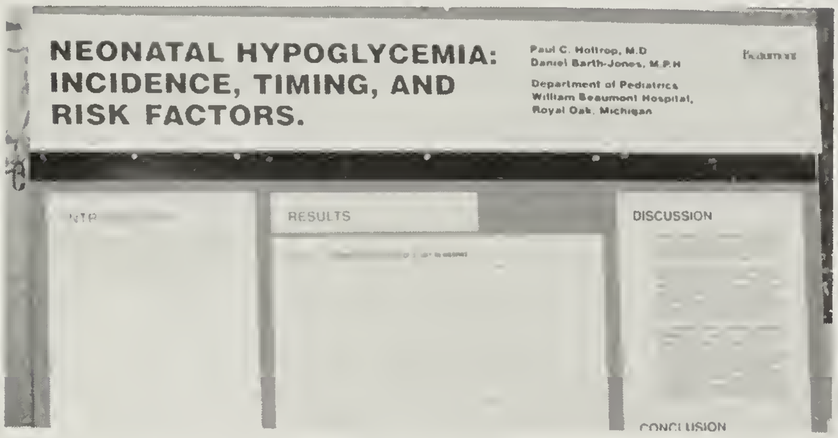
Continued from page 29

II MOTHER'S SURVEY
ING THE PREMATURE

Joyce McCabe, RN, MSN, Department of Nursing, Mercy College of Detroit, (left) is presented with the nursing poster cash award from Sandra Geller, RN, a member of the MSMS Planning Committee for the 1991 Maternal and Child Health Conference.

II: MOTHERS SURVEY
THE PREMATURE
(3) Herpes Simplex Vi
A Clinico-Patholog

Joyce McCabe, RN, (right), winner of the nursing poster award, poses with poster co-author Mary S. Wawrzynski, PhD, RN, dean of nursing and health, Madonna College, Detroit.


NEONATAL HYPOGLYCEMIA: INCIDENCE, TIMING, AND RISK FACTORS.
Paul C. Holtrop, M.D
Daniel Barth-Jones, M.P.H
Department of Pediatrics
William Beaumont Hospital,
Royal Oak, Michigan
Beaumont
RESULTS
DISCUSSION
CONCLUSION

The pediatrics poster cash award went to co-authors Paul C. Holtrop, MD, and Daniel Barth-Janes, MD, Department of Pediatrics, William Beaumont Hospital, Royal Oak, for their poster on "Neonatal Hypoglycemia: Incidence, Timing and Risk Factors."

ENDOVAGINAL ULTRASOUND EVALUATION OF INCOMPETENT CERVIX
16 Endovaginal Ultrasound Evaluat
of Incompetent Cervix

H. F. Anderson, MD, Department of Obstetrics and Gynecology, University of Michigan Medical School, is presented with the obstetrics poster cash award from Federico Mariona, MD, co-chair of the MSMS Planning Committee for the 1991 Maternal and Child Health Conference.

Eleven posters were presented at the 1991 Maternal and Child Health Conference in Dearborn. Posters were displayed throughout the two-day event held at the Ritz Carlton Hotel.

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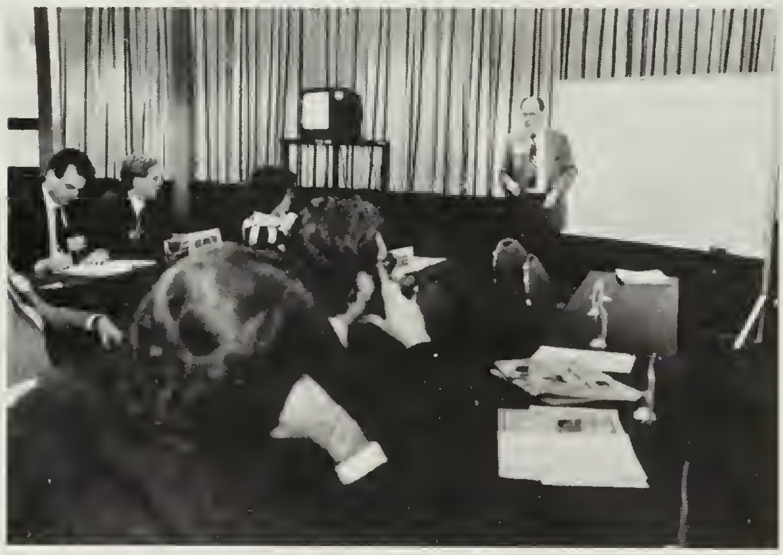
MSMS
YOUNG PHYSICIANS SECTION

Photos by Tom Gennara

Thomas J. Archambeau, MD, chairman of the MSMS Young Physicians Section, delivered the opening remarks to approximately 35 delegates and invited guests at the Section's annual meeting March 7 in East Lansing.

William A. Hazel, Jr., MD, chairman-elect of the AMA Young Physicians Section, updated MSMS YPS delegates and invited guests on AMA activities.



George Gerber, MD, associate medical director, Government Programs, Blue Cross Blue Shield of Michigan, presented delegates with an update on the RBRVS and Medicare.

Members of the MSMS Young Physicians Section Governing Council took a moment to gather with other Section members for a group photo. Pictured left to right, back row are: Thomas George, MD, former alternate delegate; Kevin M. O'Brien, MD, YPS secretary; Patrick J. Droste, MD, alternate delegate; Douglas L. Colberg, MD, delegate; Timothy T. Wellemeyer, MD, at-large member; Thomas J. Archambeau, MD, YPS immediate past chairman; and Karl Edelmann, MD, YPS vice chairman/chairman-elect. Picture left to right, front row are: Tama D. Abel, MD, YPS chairman, and Sherry L. Viola, MD, at-large member.

Two reference committees heard testimony on resolutions at the MSMS YPS annual meeting. Above are members of Reference Committee A. They are (l to r): Douglas Colberg, MD, delegate; Judy Marr, MSMS staff; Karl Edelmann, MD, reference committee chairman; Patrick J. Droste, MD, delegate, Grand Rapids; Gregory Forzley, MD, delegate, Grand Rapids; and Timothy T. Wellemeyer, MD, delegate, Holt.

Members of Reference Committee A heard testimony on resolutions at the MSMS YPS meeting in East Lansing. Pictured left to right are: Karl Edelmann, MD, chairman; Patrick J. Droste, MD; Gregory Forzley, MD; and Timothy T. Wellemeyer, MD.

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MSMS HOSPITAL MEDICAL STAFF SECTION

ANNUAL MEETING HIGHLIGHTS

Outgoing MSMS HMSS Chairman Gary D. Maynard, MD, welcomed approximately 61 delegates and invited guests to the Seventh Assembly of the MSMS Hospital Medical Staff Section held March 16 in Dearborn.

Peter A. Duhamel, MD, an at-large member of the MSMS HMSS Governing Council and vice chairman of the AMA HMSS, presented outgoing MSMS HMSS Chairman Gary D. Maynard, MD, with a plaque in recognition of his service and dedication to the Section.

Krishna Sawhney, MD, was elected to serve a two-year term as chairman of the MSMS Hospital Medical Staff Section. He replaces outgoing chairman Gary D. Maynard, MD.

S. RAGHEB
R. CRAM
M. PARKS

Two reference committees heard testimony on resolutions at the MSMS HMSS meeting. Shown above are members of Reference Committee A. They are (l to r): Ralph A. Cram, MD, Michael J. Parks, MD, James B. Wessinger, MD, and Clinton W. Wilson, MD.

Members of Reference Committee A discussed the testimony they heard on resolutions earlier in the day. Pictured left to right, clockwise, are: John A. Rupke, MD, Michael J. Parks, MD; James B. Wessinger, MD; Ralph A. Cram, MD; Clinton W. Wilson, MD; Samir Ragheb, MD; and Katie Brewbaker, MSMS staff.

Photos by Pattrick Yockey

Newly-elected members of the MSMS HMSS Governing Council took a moment to gather for a photo. They are (l to r): Harry Doerr, MD, alternate delegate; Robert C. Borchak, MD, HMSS member at large; Edward J. Rutkowski, MD, HMSS vice chairman; Krishna Sawhney, MD, HMSS chairman; John A. Rupke, MD, delegate; and B.L. Pederson, MD, HMSS secretary.

John T. Kelly, MD, PhD, director of quality assurance, American Medical Association, was the featured luncheon speaker at the MSMS HMSS meeting. The subject of his presentation was, "Practice Parameters: Key to Quality Advancement."

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MSMS
SECTION FOR INTERNATIONAL MEDICAL GRADUATES

ANNUAL MEETING HIGHLIGHTS

Photos by Ron Ponkey

"I plan to continue serving you," Busharat Ahmad, MD, immediate past chairman of the MSMS Section for International Medical Graduates, told approximately 67 delegates and invited guests at the 1991 IMG Section meeting March 23. "I am not moving away from the scene. I will be very actively involved in this Section and at the state level in the years to come. Hopefully, I will be able to take your message to the AMA."

MICHIGAN STATE

"Our Section is at a crossroads," said AppaRao Mukkamala, MD, newly-elected chairman of the IMG Section. "The time to act..to revitalize and reenergize the Section...is now. We must make good use of our Section."

John H. Ring, MD, president-elect of the American Medical Association, was one of two luncheon speakers at the IMG Section meeting. In his presentation, Doctor Ring discussed the AMA's stand on several issues of interest to IMGs, including discrimination in licensing and residency selection. Doctor Ring also described activities the AMA is undertaking on behalf of IMGs.

Leaders of the IMG Section, MSMS and the AMA took a moment to gather for a photo during the IMG Section meeting held at the Ritz Carlton Hotel, Dearborn. From left to right, back row are: Frank B. Walker, MD, member, AMA Board of Trustees; Filiberto Cavazos, MD, secretary-treasurer, IMG Section; Krishna Sawhney, MD, immediate past vice chairman, IMG Section; Busharat Ahmad, MD, immediate past chairman, IMG Section; Byung Lee, MD, immediate past at-large member, IMG Section; AppaRao Mukkamala, MD, newly-elected chairman, IMG Section; and Samir Yahia, MD, newly-elected vice chairman, IMG Section. From left to right, front row are: Ada van Vloten, MD, MSMS alternate delegate, IMG Section; Susan H. Adelman, MD, MSMS president; John Ring, MD, AMA president-elect; and Mrs. Ring.

Krishna Sawhney, MD, immediate past vice-chairman, IMG Section (left), holds a plaque presented to Busharat Ahmad, MD (right), in recognition of his "years of dedication on behalf of international medical graduates in the United States."

Several resolutions considered at the Third Annual Meeting of the MSMS Section for IMGs generated considerable testimony from IMG delegates. A total of 19 resolutions were debated at the meeting.

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DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS ISSUE 4 MAY 1991

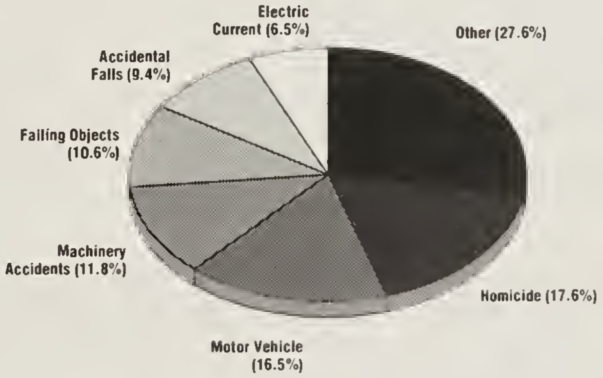
Medical Inquirer

OCCUPATIONAL DISEASE IN MICHIGAN

There are no reliable national or state surveillance systems for occupational disease.[1] Most workers who develop occupational disease do not apply for worker's compensation. The following estimates of occupational disease in Michigan are based on extrapolations from disease reports to state health departments[2,3,4], death certificates, hospital discharge data[5,6], worker compensation data[7], reports from employers[8], and surveys reported in the medical literature[9,10]. The estimates presented here probably underestimate the true burden of occupational disease in Michigan.

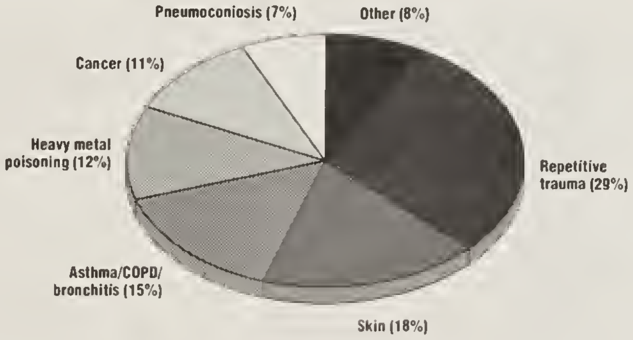
MICHIGAN ACUTE WORK-RELATED FATALITIES BY CAUSE 1988

There are approximately 170 acute work-related fatalities noted annually on death certificates in Michigan. Additionally, for 10 percent of cancer deaths, for one to three percent of chronic respiratory disease, and for one to three percent of cardiovascular deaths, occupation is estimated to be a significant contributor. This is equal to approximately 3,000 deaths per year out of a total of 80,000 Michigan deaths per year.



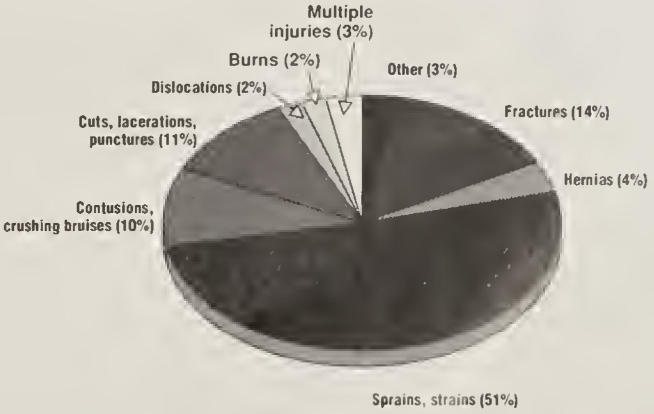
MICHIGAN WORK-RELATED ILLNESSES BY DISEASE TYPE 1988

An estimated 12,000 to 14,000 workers develop new occupational diseases per year in Michigan.



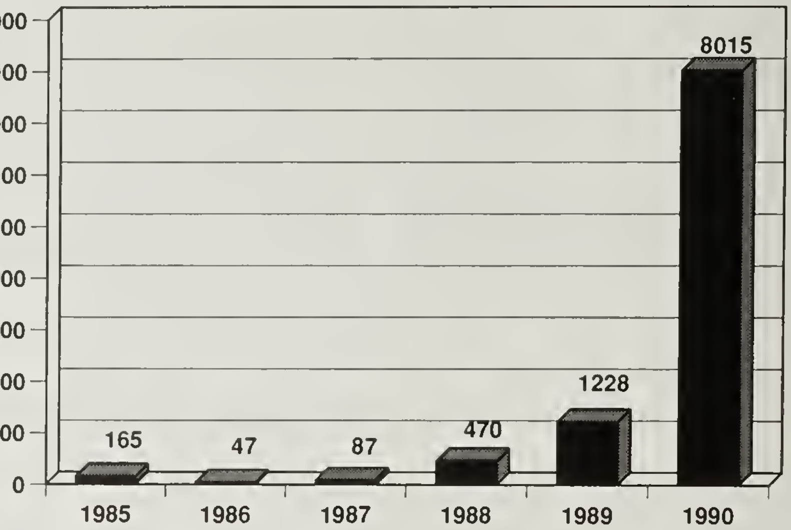
MICHIGAN NON-FATAL INJURIES BY TYPE OF INJURY 1988

An estimated 74,500 to 230,700 non-fatal workplace injuries occur each year in Michigan. The low estimate is based on state worker compensation records. The high estimate is based on data supplied by employers to the Michigan Department of Labor.



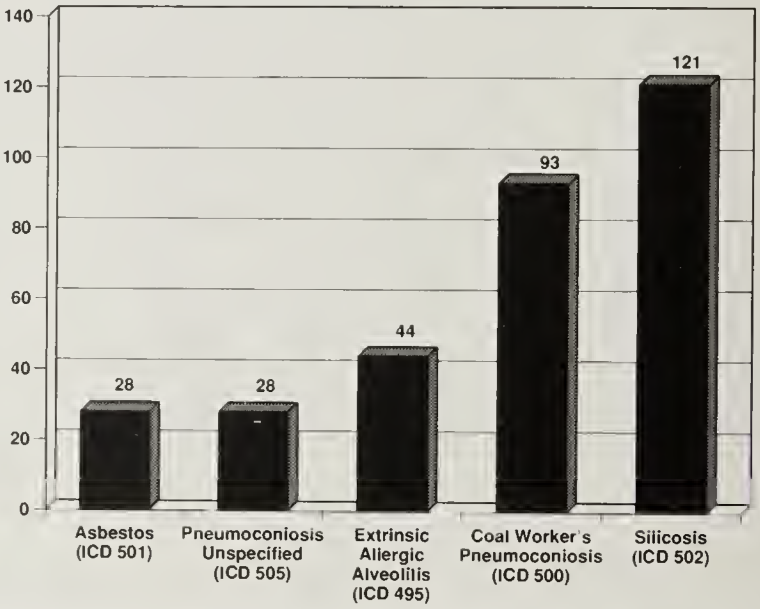
OCCUPATIONAL DISEASE REPORTS TO THE STATE HEALTH DEPARTMENT MICHIGAN 1985-1990

Physicians, hospitals, clinics and employers are required to report occupational disease (not injuries) to the Michigan Department of Public Health (MDPH). Since 1988, MDPH has been reminding physicians and hospitals of the reporting requirements.



HOSPITAL DISCHARGE DIAGNOSES PER YEAR FOR THE PNEUMOCONIOSES AND EXTRINSIC ALLERGIC ALVEOLITIS, MICHIGAN 1982-1988

Hospital discharge data can be used to identify the definite occupational diseases, pneumoconiosis and extrinsic allergic alveolitis. There are approximately 300 hospital discharges for occupational lung disease per year. It is estimated there are two non-hospitalized patients for every hospitalized patient, or 900 newly diagnosed Michigan residents with pneumoconiosis each year. ■



Prepared by Kenneth D. Rosenman, M.D., Associate Professor of Medicine, Michigan State University.

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Medical Inquirer

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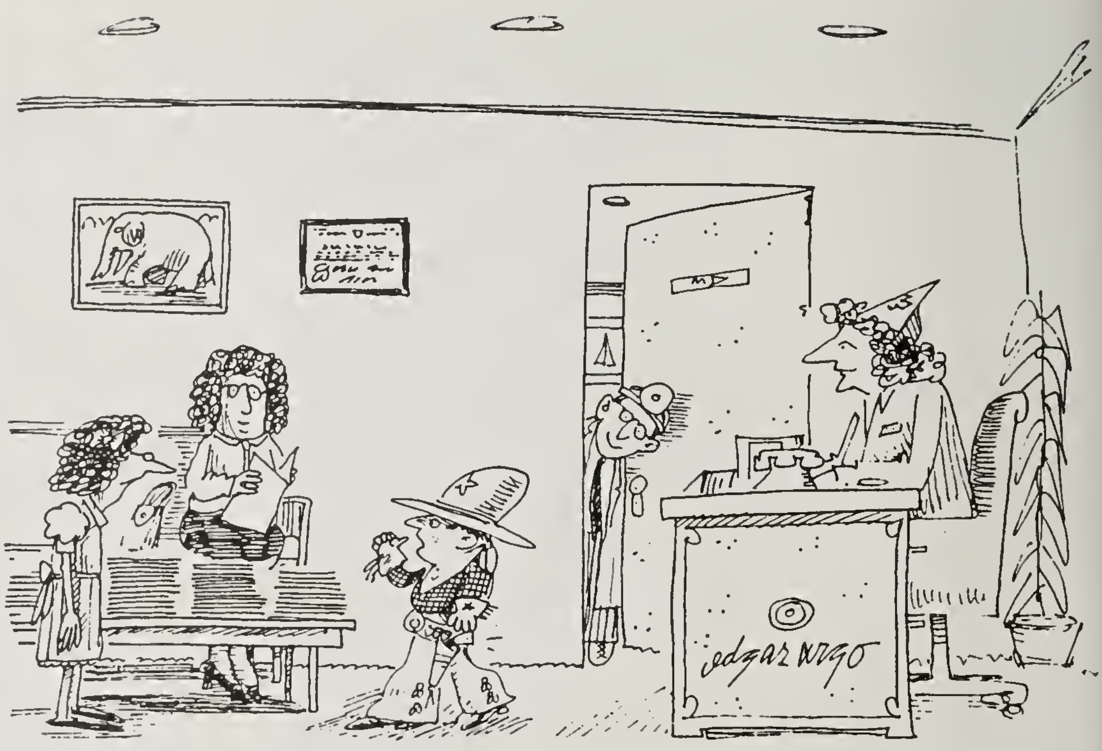

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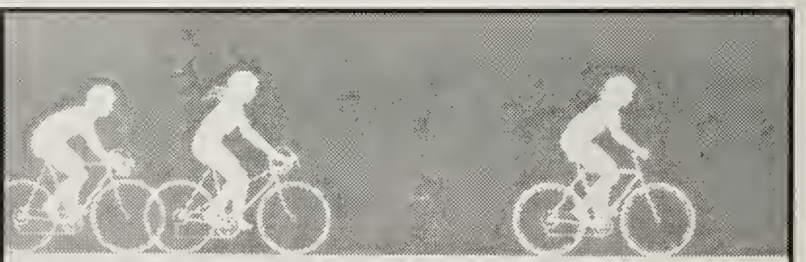

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MSMS Board of Directors

Two guest speakers addressed members of the MSMS Board of Directors at a meeting held March 20 at MSMS headquarters. Photo highlights of each presentation appear below.

AMA Executive Vice President James S. Todd, MD, outlined his goals for the AMA and organized medicine during an MSMS Board of Directors meeting March 20. Saying that the AMA and organized medicine need more focus, Doctor Todd discussed some of the changes the AMA is performing to bring that about, including a staff reorganization. Physicians must make the public more aware of the good they do through increasing their visibility and displaying their competence, he said.

Photos by Pattrick Yockey

As with many other state agencies, recent state budget cuts have caused a downsizing of the Michigan Office of Services to the Aging (OSA), Director Nancy Crandall told the MSMS Board of Directors at its March 20 meeting. Ms. Crandall told the Board that, since her appointment by Gov. Engler last November, 20 positions have been cut from her staff. "We're now trying to figure out how to continue priority programs with less money," she said.

DEATHS

Arthur R. Bloom, MD
Southfield

Arthur R. Bloom, MD, a radiologist, died February 17. He was 93. Doctor Bloom graduated from the University of Illinois Medical School. In 1927 he moved to Detroit where he had a private practice and served as a consultant to numerous medical clinics. Doctor Bloom retired in the mid 1970s. He was a member of the Radiology Association, the American College of Radiology, the American Medical Association and MSMS.

Harold E. Cross, MD
Grosse Pointe Shores

Harold E. Cross, MD, a general practitioner, died February 11. He was 82. Doctor Cross received his medical degree from Wayne State School of Medicine in 1940. He practiced in Detroit and Warren for more than 50 years. Doctor Cross served as the former chief of staff at Cottage Hospital, Grosse Pointe Shores, where he delivered more than 3,000 babies during his career. He was a member of the International College of Surgeons, the American Academy of Family Practice and MSMS.

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Carl M. Hansen, MD
Stanton

Carl M. Hansen, MD, a general practitioner, died February 14. He was 78. Doctor Hansen attended Michigan State University and Central State College. He received his medical degree from Louisville School of Medicine and served his residency at Butterworth Hospital, Grand Rapids. Doctor Hansen had a private practice in Stanton and was affiliated with United Memorial Hospital, Greenville, and Butterworth Hospital, Grand Rapids. He also served as Montcalm County medical examiner for many years. Doctor Hansen was a member of the American Medical Association, the American Society of Abdominal Surgeons and MSMS.

Barnard L. Lieberman, MD
Bradenton, Florida

Barnard L. Lieberman, MD, an internist, died January 26. He was 88. Doctor Lieberman was the former chief of staff at North Detroit General Hospital for 21 years. He retired in 1958 and moved to Florida. He was a life member of the American Medical Association and MSMS.

Richard William Neumann, MD
Marquette

Richard William Neumann, MD, an orthopedic surgeon, died March 2. He was 56. Doctor Neumann earned both his undergraduate doctorate degrees from the University of Michigan. He served his internship at Minneapolis General Hospital, and completed his residency in orthopedic surgery at the University of Minnesota. In addition, he completed a hand surgery fellowship in New Orleans. Doctor Neumann was a senior partner affiliated with Orthopedic Surgery Associates, Marquette, for 22 years. He was a fellow of the American Academy of Orthopedic Surgeons and a member of the American Medical Association, the Riordan Hand Society and MSMS.

Mary H. Rieger, MD
Birmingham

Mary H. Rieger, MD, a general practitioner, died February 24. She was 98. Doctor Rieger graduated from Washburn College and received her bachelor's degree from Detroit College of Medicine and Surgery in 1933. She received her medical degree from Wayne State University School of Medicine. She did her postgraduate work in clinical psychology at Harvard University. Doctor Rieger served on staff of Hutzel Hospital, Detroit, and practiced in the Detroit Metro area for more than 40 years. She was a member of the Wayne County Medical Society, the American Medical Association, the American Academy of General Practice and MSMS.

Arthur B. Thompson, MD
Saginaw

Arthur B. Thompson, MD, a doctor of occupational medicine, died February 27. He was 81. Doctor Thompson graduated from Olivet College and received his medical degree from McGill University, Montreal, Canada. He entered his private practice in 1937. He served as Medical Director for General Motors Corporation, Saginaw and Bay City, retiring in 1974. He then joined the Saginaw General Hospital Emergency Room Staff and became employed by Dow Chemical, Midland. Doctor Thompson was a member of the American Occupational Medical Association, the American Medical Association, the Saginaw County Medical Society and MSMS.

Robert J. Wilson, MD
Comstock Park

Robert J. Wilson, MD, an internist, died February 24. He was 61. Doctor Wilson was a University of Michigan Medical School graduate. He was a practicing physician at Butterworth Hospital, Grand Rapids, for 30 years. Doctor Wilson was a member of Kent County Medical Society and MSMS.

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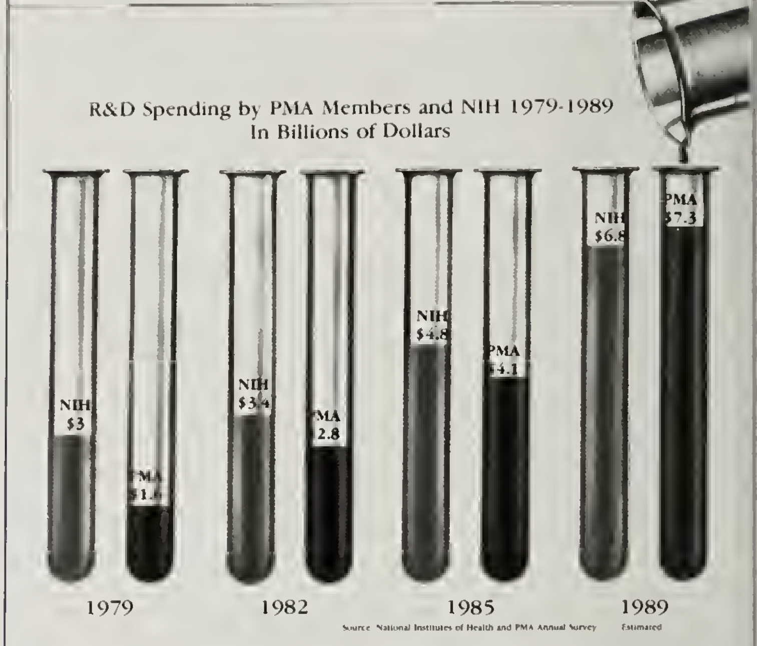

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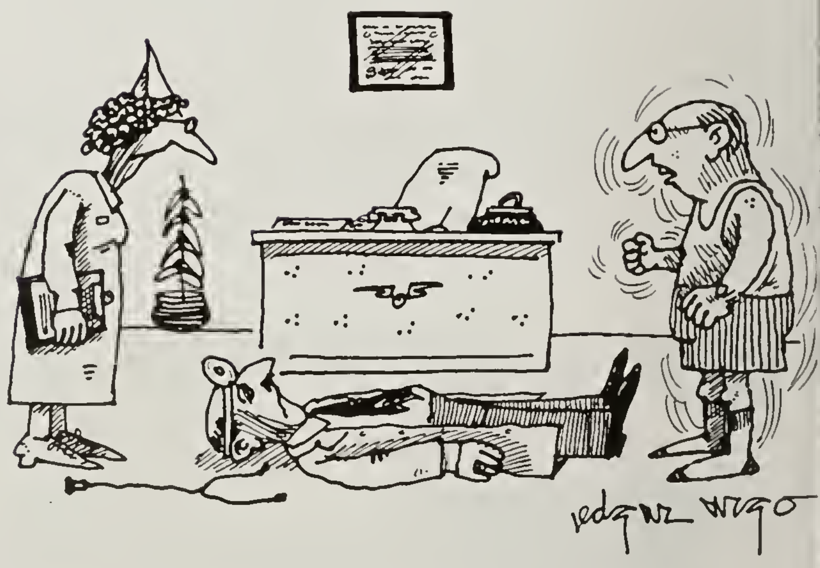

"HE SAID I WAS CONSUMING TOO MUCH CAFFEINE, SO I PUNCHED HIS LIGHTS OUT."

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Yasmeen A. Ahmad, MD — PN/PD
3800 Woodward #700
Detroit 48201

Robert J. Austin, MD — OBG
252 E. Lovell
Kalamazoo 49007

Philip T. Baty, MD — FP
200 Jefferson, SE
Grand Rapids 49503

Padmanabha R. Betina, MD — IM/FP
126 College St.
Battle Creek 49017

Glenn G. Betrus, MD — U
23045 Murray
Dearborn 48128

Lawrence E. Blase, MD — IM
29745 Rock Creek
Southfield 48076

Richard E. Bruner, DO — FP
907 Pine St.
Marquette 49855

Marcia B. Cardelli, MD — D
800 S. Admas
Birmingham 48009

Soon Ah Choi, MD — IM
3280 N. Elms Rd.
Flushing 48433

William L. Cox, MD — ORS/HS
15777 Northline Rd. #202
Southgate 48195

D. A. Cusumano, III, MD — IM
19697 E. Eight Mile Rd.
St. Clair Shores 48080

V. R. Dedicatoria, MD — FP
1000 Houghton Ave.
Saginaw 48602

Gary W. Easterling, MD — OBG
24739 New York
Dearborn 48124

Juan J. Geldres, MD — GS/TS
4014 S. River Rd. Bldg. 1-B
St. Clair 48079

Venkatesan Gorantla, MD — NPM
1447 N. Harrison
Saginaw 48602

Robert F. Han, MD — IM
1200 Lalley Rd.
Iron Mountain 49935

David W. Hershey, MD — P/PYM
825 Parchment Dr., SE
Grand Rapids 49546

Nelson B. Isada, MD — IM/OBG
4707 St. Antoine
Detroit 48201

Calvin Johnson, MD — OBS/PAN
4707 St. Antoine
Detroit 48201

Brian R. McCardel, MD — ORS
901 E. Mt. Hope
Lansing 48910

Percy H. McDonald, MD — OTO
1212 Richardson St.
Port Huron 48060

Glenn E. Merz, MD — FP
1963 Gatewood, SW
Wyoming 49509

Richard B. Michelson, MD — GPM
363 W. Big Beaver
Troy 48084

Syed G. Mohiuddin, MD — PD
3257 Davison Rd.
Lapeer 48446

Ureddi R. Mullangi, MD — DR
1233 Springborrow Dr.
Flint 48532

Richard J. Nelson, MD — OTO
420 Parkview
Plymouth 48170

Geoffrey D. Osgood, MD — PS/GS
2603 Electric Ave.
Port Huron 48060

Hina B. Papo, MD — IM
2090 Commonwealth Blvd.
Ann Arbor 48105

S. R. A. Paruchuri, MD — AN
3121 Davenport
Saginaw 48602

V. R. Ramakrishnan, MD — VS/GS
23023 Orchard Lake Rd.
Farmington 48336

Isabello C. Reyes, Jr., MD — IM
21679 Hidden Rivers Dr.
Southfield 48075

Sara L. Rivette, MD — IM
3424 Davenport
Saginaw 48602

Richard A. Rovin, MD — NS
1414 W. Fair Ave.
Marquette 49855

Raymond E.F. Schmoke, MD — IM
1400 E. Parkdale
Manistee 49660

Rex Schultz, MD — GS
3031 N. Altadean
Royal Oak 48073

Victoria C. Serbia, MD — P/CHP
2614 Richards, SE
Grand Rapids 49506

Cesario Y. Solarte, MD — IM
2255 Fort St.
Lincoln Park 48146

Cesar A. Sturla, MD — IM
20311 Farmington Rd.
Livonia 48152

Samuel E. Talsma, MD — AN
5333 McAuley Dr. R-6115
Ypsilanti 48197

Steven D. Tennenberg, MD — GS
14641 Sherwood Ct.
Oak Park 48237

Steven J. Thiry, MD — FP
3200 W. Liberty
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Jean B. Thomas, MD — FP
200 Jefferson, SE
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Ralph J. Tidalgo, MD — IM
2255 Fort St.
Lincoln Park 48246

Steven A. Vix, MD — IM
504 W. Harrie St.
Newberry 49868

Elizabeth K. Wilson, MD — FP
309 S. Fifth St.
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Catherine A. Wonski, MD — FP
3427 College Ave., NE
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Mary Frances Woods, MD — OBG
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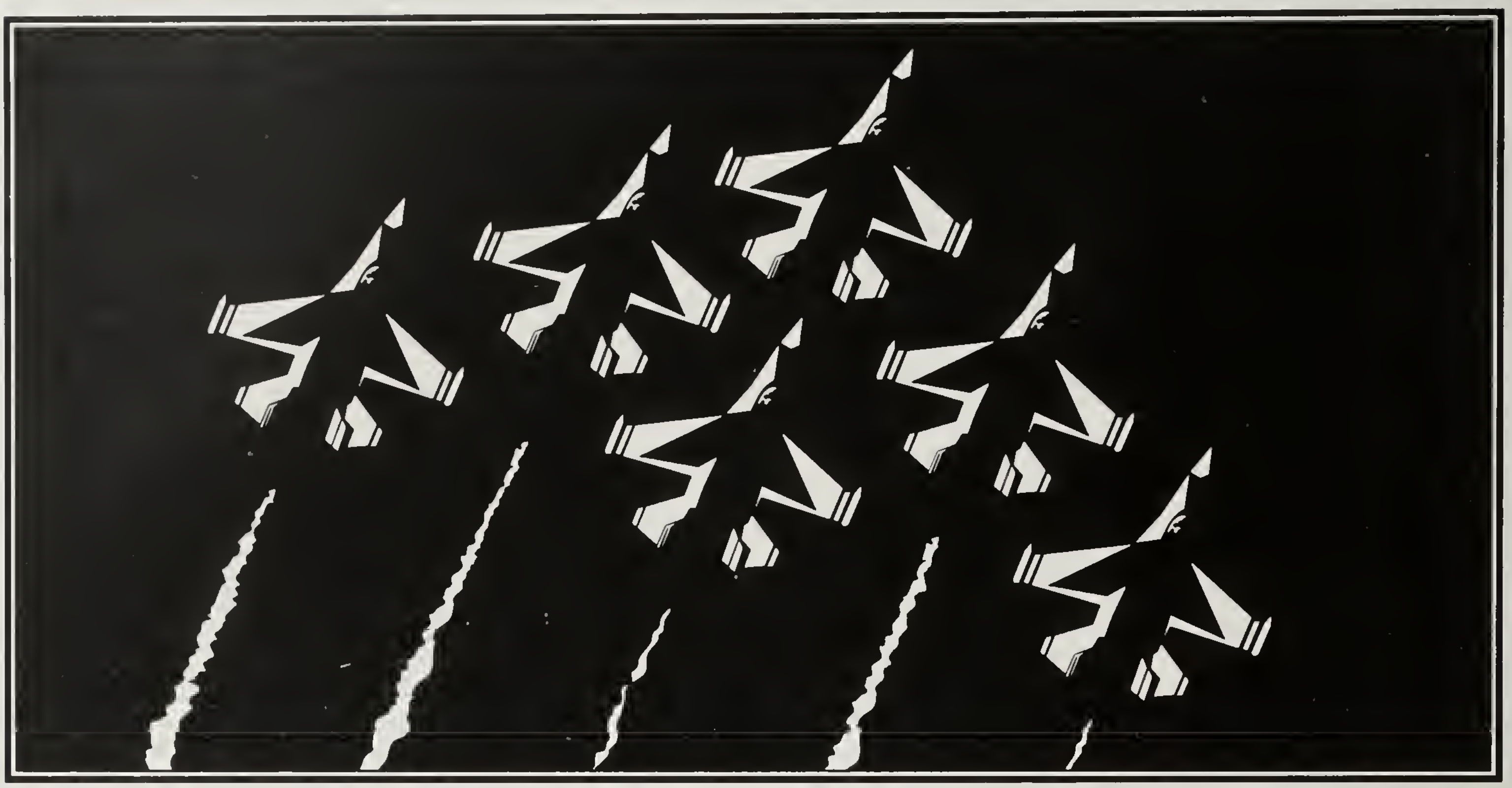

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CBC

MEETINGS

MSMS Meetings

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

6, PSG, Michigan Society of Internal Medicine, Spring Meeting; Embassy Suites Hotel, Southfield, MI. Contact: Caroline Kimmel, Executive Secretary (517) 336-7570.

9, MSMS Practice Management Seminars "Financial Planning" and "Health Law Update", Hyatt Regency, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

9, MSMS Risk Management Seminar, Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

15,16, MSMS Practice Management Seminar, "Medicare Update," Amway Grand, Grand Rapids, May 15; Dearborn Inn, Dearborn, May 16. Contact: MSMS Office of Physician Education, (517) 337-1351.

21, MSMS Risk Management Seminar, Waterfront Inn, Traverse City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

24, PSG, Michigan Medical Group Managers Association, Spring Conference; Dealing with Change, Holiday Inn University Place, East Lansing, MI. Contact: Caroline Kimmel, Executive Secretary (517) 336-7570.

30, MSMS Risk Management Seminar, Kellogg Center, East Lansing, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

AMA Meetings

June

23-27, AMA House of Delegates Annual Meeting, Chicago Hilton & Towers, Chicago, IL 60611. Contact: Jacquelyn Craig, AMA, 515 N. State St., Chicago, IL 60610, 312-464-5000.

Michigan Specialty Society Meetings

May

18, Notes on Transcultural Issues in Psychoanalysis and Psychoanalytic Psychotherapy, 16310 W. Twelve Mile Rd., Suite 204, Southfield MI. Contact: Shirley Seffinger or Colleen Jaeger (313) 557-8633 or 559-5855.

26-28, Michigan Chapter American Academy of Pediatrics Annual Meeting, Shanty Creek Resort, Bellaire, MI. Contact: John Romanik, MD, 39500 West 10 Mile Rd., Novi, MI 48375, (313) 478-8040.

National Specialty Society Meetings

May

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11, American Psychiatric Association Annual Meeting, New Orleans, LA. Contact: (202) 682-6000.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gatroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-June/1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

May

7,14, The Bar-Levav Educational Association, Ongoing Seminar Series, "Separating Thoughts from Feelings: An Essential Skill for the Psychotherapist." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

13, Adolescents and HIV/AIDS: Strategies for Today. Sponsor: Children's Hospital of Michigan. **Contact:** Valerie Overholt, DO, Medical Director, Taylor Teen Health Center, 21115 Eureka Road, Taylor MI 48180, (313) 374-2273. **Approved for:** 7 hours Category I Credit.

16-17, The Restenosis Summit III. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School; Division of Cardiology, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

17-18, 63rd Annual Ophthalmology Spring Postgraduate Conference: Lasers In Ophthalmology. Applications and New Developments. Location: University of Michigan, W.K. Kellogg Eye Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Ophthalmology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 11 hours Category I Credit.

20-22, Airborne Pollen and Fungus Spore Identification: A Hands-On Workshop. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Department of Postgraduate Medicine, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 17 hours Category I Credit.

21,28, The Bar-Levav Educational Association, Ongoing Seminar Series, "Fathering in the Family and in Psychotherapy-Videotape and Discussion." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential

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CATEGORY I COURSES

Town Center, Southfield, MI 48075, (313) 353-533. **Approved for:** 4 hours Category I Credit.

June

4,11, The Bar-Levav Educational Association, Ongoing Seminar Series, "Instilling Self Restraint: Another Step in the War Against Narcissism." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

5-7, 18th Annual Symposium on Current Topics in Blood Banking. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

10-11, Fifth Annual Cardiology Symposium for Nurses. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Cardiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

13-15, Microscopic Endolaryngeal Surgery: New and Advanced Techniques of Diagnostic Treatment. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

17-21, 27th Annual Northern Michigan Summer Conference. Location: Shanty Creek Resort, Bellaire, Michigan. Sponsor: University of Michigan Medical School, Department of Family Practice. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 764-2288. **Approved for:** 20 hours Category I Credit.

21,23, Joint Conference for Primary Care Physicians Featuring: Rheumatology, Neurology, Dermatology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** Ingham Medical Center, Department of Continuing Medical Education, and Michigan State University, Department of Medicine, College of Human Medicine. **Contact:** M.A. Taylor, Director, CME, Ingham Medical Center, (517) 334-2107. **Approved for:** 12 hours Category I Credit.

Continued on page 53.

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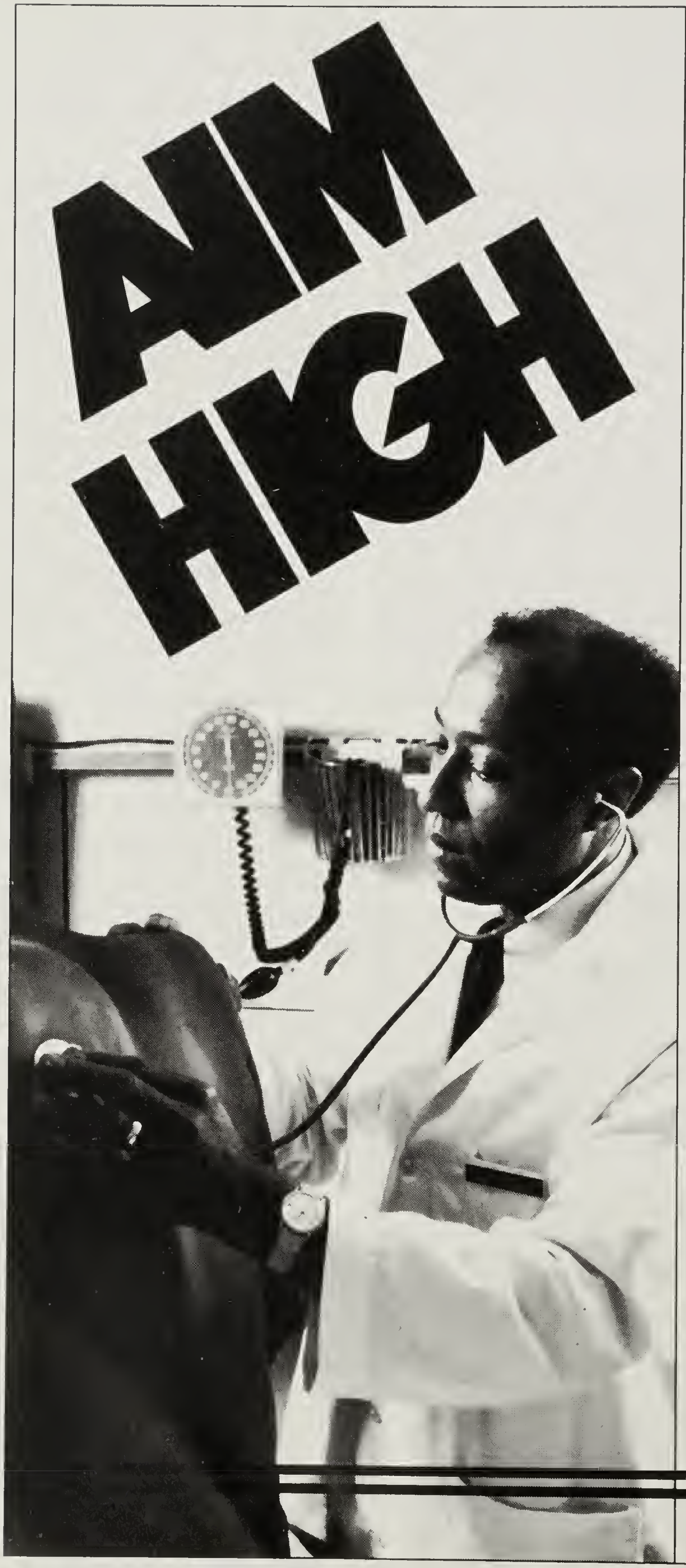

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CATEGORY I COURSES

Continued from page 51

July

8-11, Mackinac Island Imaging Conference. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073 (313) 551-6199. **Approved for:** 21 hours Category I Credit.

25-26, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village, Michigan. **Sponsor:** Munson Medical Center. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386, (616) 922-9546. **Approved for:** 9-11 hours Category I Credit.

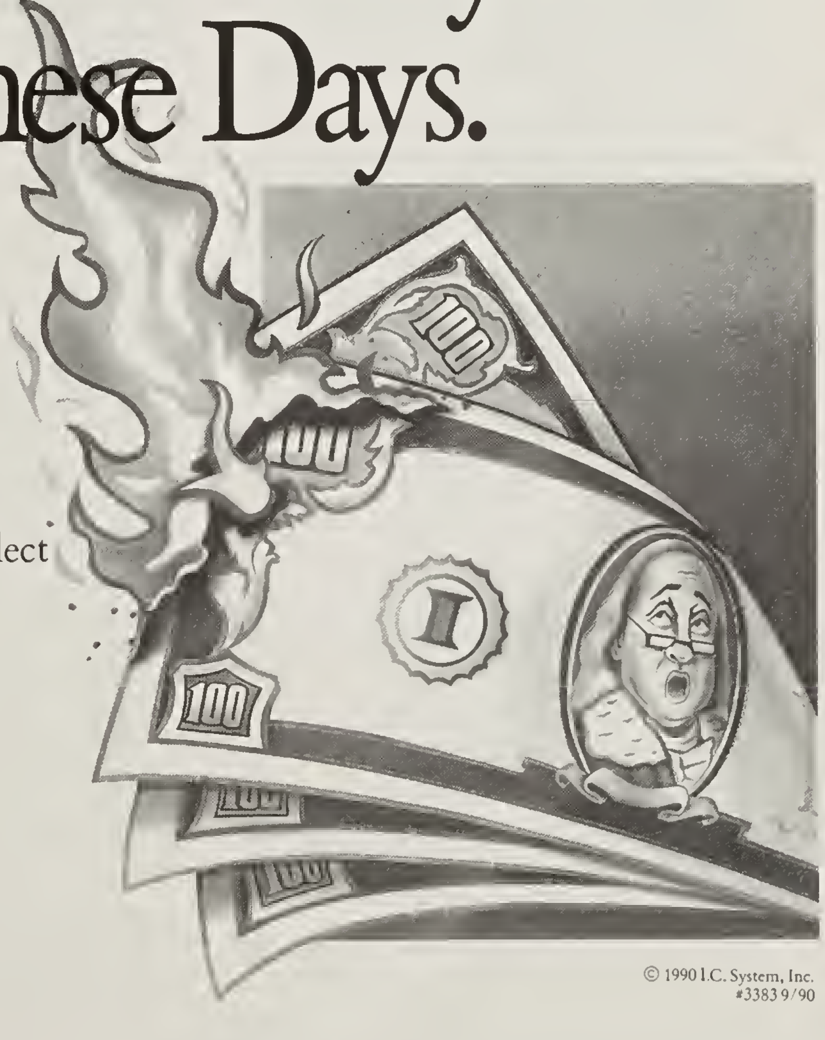
28-31, 17th Annual Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

August

8-11, Cardiology Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 12 hours Category I Credit.

10-11, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village, Michigan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine and Michigan Diabetes Research and Training Center. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Eduation, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 7 hours Category I Credit.

12-13, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.



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DEAN MEDICAL CENTER: A 220-plus physician multi-specialty group is actively seeking a BE/BC **General Internist** with interest in pediatrics to work at the Stoughton and Evansville, WI, offices located approximately 20 miles from Madison. Call would be shared with two internists based in Stoughton. There is also four Family Practice physicians and one General Surgeon located at the Stoughton office, along with full sub-specialty support in Madison. Excellent compensation and benefits provided with this position. Please submit CV and letter of introduction to: Scott M. Lindblom, Dean Medical Center, 1313 Fish Hatchery Road, Madison, WI 53715, or call work (608) 252-8022 or home (608) 276-8989.

DERMATOLOGIST, PSYCHIATRIST, ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE: A progressive, 126-bed, two hospital system is seeking the above specialties to establish practices in the **Iron Mountain** area of **Michigan's Upper Peninsula.** Must have BE/BC. Located 100 miles north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully staffed special diagnostic department. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4500.

EMERGENCY MEDICINE: Marshfield Clinic-Lakeland Center, located in the beautiful Lakeland area of **Northern Wisconsin**, is seeking an **ER Physician.** This individual must be BE-/BC in FP, IM, or EM. This opportunity offers a challenging variety of patients, within a multispecialty group representing 13 specialties available for back-up. The Lakeland area offers a unique recreation-oriented lifestyle and this position with a 48-hour work week will afford you the leisure time to enjoy it. Compensation includes a competitive salary along with one of the finest fringe benefit packages in the country. If you want to combine professional excellence with personal satisfaction and this opportunity sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449 or call (800) 826-2345, ext. 5376.

EMERGENCY PHYSICIAN: Experienced physician for low acuity emergency room in Macomb County. 5,000 visits per year, minimal night volume. Congenial surroundings and staff with ample time for study, etc. Would suit emergency physician or family practitioner looking for a slower pace. Twelve and twenty-four hour shifts. Full and part time position available. ACLS necessary. Call (313) 642-9893 or send CV to P. O. Box 2770, Southfield, MI 48037.

FAMILY PHYSICIAN: Wanted to join non-profit community health center program. BC/BE. Modern facility in rural community in central **Upper Peninsula of Michigan.** OB and hospital required. Competitive salary, excellent benefits. Possible loan repayment. Immediate opening. Send CV to: Donna Jaksic, Executive Director, Upper Peninsula Association of Rural Health Services, 220 W. Washington, Suite 430, Marquette, MI 49855: (906) 228-3613.

FAMILY PRACTICE: A prime Family Practice awaits you in sunny, metropolitan **Phoenix, Arizona**. We have additional FP opportunities in picturesque **Wisconsin** and **Illinois**. Available benefits include student loan repayment, CME allowance, relocation expense assistance and more. For confidential inquiry, call (800) 969-7715. Dan Jones, Gielow/Laske Associates, Inc., 306 N. Milwaukee Street, Milwaukee, Wisconsin 53202.

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FAMILY PRACTICE: Marshfield Clinic, a 350-physician multi-specialty group practice, is seeking BE/BC **Family Practitioners** to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multi-specialty groups of 35. Positions are available in Westcentral, Northwestern, and Northcentral **Wisconsin.** These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers and streams. All are ideally suited for physicians seeking to combine professional excellence in a Midwest, family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700 with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449, or call (800) 826-2345, extension 5376.

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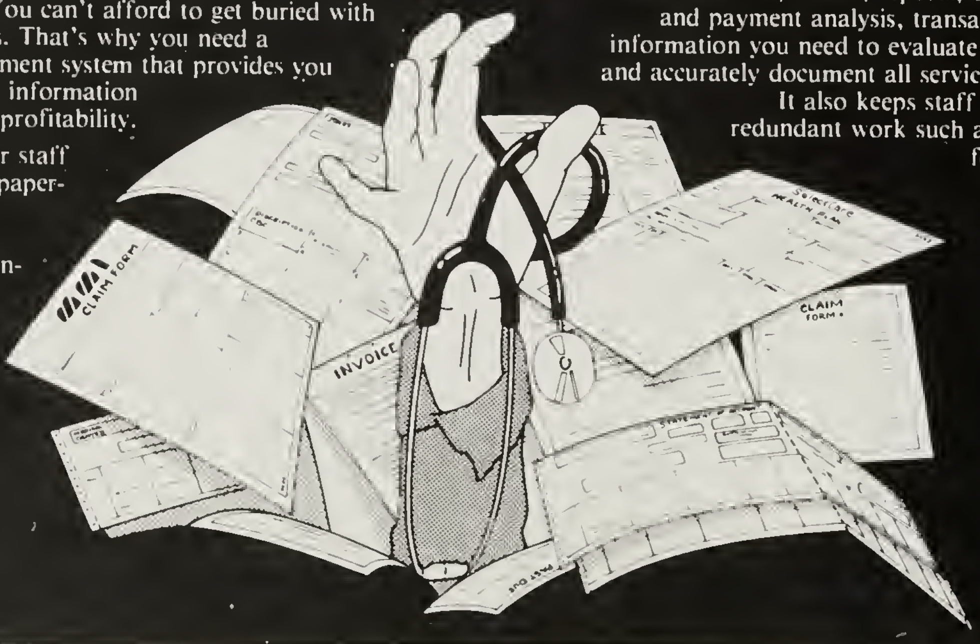

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Meade Leasing	31
Medfirst	42
Medical Automation	10
Medical Billing Service	2
Medical Newsletter	51
Medical Search Group	54
Medsys	28
MPMLC	IFC
Palisades Pharmaceuticals	46
PC Medical	50
Pennock Hospital	38
Physician Service Group	1
PICOM	15, 33-34
PMG	50
Prescott, Ball & Turben	42
Shearson Lehman Bros.	22
St. Luke's	5
US Air Force	52

PRESIDENT'S PAGE

We must match our desires with reality

By Robert D. Burton, MD

On a recent trip to India, I was particularly interested in Bombay because it was home to one of my favorite authors, Rudyard Kipling.

I've always enjoyed Kipling's works, Gunga Din, Kim, The Jungle Book. I plan to use one of my favorite quotes from Kipling as a guide, and to set the tone for my presidency.

The quote is this: "If you can keep your head when all about you are losing theirs and blaming it on you, then you are a man, my son."

I'd like to paraphrase this quote to say: "If you can keep your head when all about you are losing theirs and blaming it on you, then you are a *doctor,* my child."

This is typical of the situation we find ourselves in these days as doctors. Everyone around us seems to be losing their heads and blaming it on us. But we, above all, cannot afford to lose our cool. We must remain calm, but firm. We must be forthright. We must hold our ground as the tempest swirling around us threatens to erode our very foundation. We must be doctors. We must draw a line in the sand and then stand prepared to do everything in our power — and we really do have quite a lot of power when harnessed properly — to win the battle.

That's easy to say. But as we are attacked daily on every conceivable front, it's not that simple. How do we do it? How do we maintain what we have always stood for in the face of such adversity?

Let me tell you how I do it, and how I plan to face these problems during my MSMS presidency.

My wife will tell you that I am the most optimistic man on earth. But I am not blindly optimistic.

No, the secret of my optimism is to balance desires with reality. The closer the two are in the beginning, the better the chance for success. When you are way off to one side in your desire for the ideal, and when reality is way off to the other side, your chance of successfully achieving your desire is minimal. But when your desire is in closer accord with reality, you have a much better chance at affecting that reality and getting what you desire.

Professional liability one example

Since this month's *Michigan Medicine* is dedicated to the continuing professional liability problem, let me use this issue as an example.

What is the ideal in professional liability? The ideal is way off to one side by itself. The ideal is having the legislature pass a new law banning trial lawyers from Michigan. The ideal is having a legislature that agrees there is truly a problem and wants to do something about it. The ideal is having 100 percent patient compliance with our treatment and instructions. The ideal is 18,000 doctors in Michigan treating nine million people without a single mistake, or a single maloccurrence.

But wait. Reality is off to the other side. Reality is that Michigan has a huge number of trial attorneys who are very well organized and are very well ingrained in the fabric of Michigan politics. The reality is that the legislature remains split along party lines on the liability issue; the Republicans control the Senate and the Governor's office, but Democrats still own the House. The reality is that many patients are non-compliant, and that doctors do make mistakes and there are many, many cases of maloccurrence masquerading in the courts as malpractice.

So what do we do? We develop a plan of action based on desires that fit into current reality, and we use every resource available to make them a reality.

Our strategy for professional liability reform is this. We will work in a coalition with our brethren from the Michigan Association of Osteopathic Physicians and Surgeons and with the Michigan Hospital Association to support tort reform and an alternative dispute resolution system. Both are contained in Senator Dan DeGrow's new bills introduced on April 9 that we call "the Michigan Alternative."

The Michigan Alternative will offer a patient either the traditional court system or a new, faster alternative dispute resolution system. The reform includes a limit of $1.5 million on economic damages and a $225,000 limit on non-economic damages. It eliminates three important exceptions on the current non-economic limit and it reduces the statute of limitations in several areas. The Michigan Alternative also calls for stricter criteria for expert witness qualifications and requires 180-day notice to file a suit.

But being realistic, we are not putting all of our eggs in one basket. We have other desires. One is countersuit legislation. Another is a state legal expense fund for physicians offering prenatal, obstetrical or pediatric care to Medicaid-eligible women.

We also plan to expand our coalition to hundreds of businesses, senior groups, consumer groups, professional associations and local governments. We are asking them to join us in petitioning the Michigan Supreme Court to re-institute a sliding scale contingency fee for trial attorneys. Currently, trial lawyers take a third of most settlements or awards. We are asking the Supreme Court to adopt a sliding scale, where the percentage an attorney is allowed to take goes down as the amount recovered goes up.

And finally, we will support an improved physician licensing and discipline system. The improved system will include a nine-month limit on actions and additional funding for more investigative staff.

MSMS has been vitally active in shaping these proposals. Up to this point, we have kept our heads and we have matched our desires as closely as possible with reality. Now we must remain calm, but firm. Be forthright. Draw that line in the sand. Hold our ground. Because our cause is right. ■

Doctor Burton is MSMS president.

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MICHIGAN MEDICINE

29 COVER STORY

MSMS ANNUAL REPORT

MSMS has been busy on many fronts over the past year. Activites ranged from forming the Task Force on Chemical Dependency and putting together 156 health professional, lawyer, and law enforcement teams to present anti-drug programs in Detroit elementary schools, to several legislative efforts aimed at establishing an alternative system for settling professional liability claims and instituting needed tort reforms. A review of all the year's activities is included in the 1990-91 MSMS Annual Report. The 16-page report includes a letter to the members from MSMS Executive Director William E. Madigan; a salute to 1990-91 MSMS officers and board members; a balance sheet and statement of revenues and expenses; and an auditor's report. Also included is a list of "Whom to Call" at MSMS headquarters.

Michigan
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Medical
Society

Page 29

FEATURES

14 MSMS PRESIDENTIAL PROFILE
An indepth profile of Robert D. Burton, MD, the new president of MSMS.
–BY RANDALL BRAAKSMA

17 HISTORY OF MDS IN MICHIGAN
An interesting account of the many accomplishments made by physicians in Michigan since the year 1700.
–BY HERB AUER

25 A MESSAGE TO MSMS AUXILIANS
–BY LOIS DUHAMEL

27 DELTA DENTAL PLAN OPEN ENROLLMENT
MSMS members have until June 30 to enroll.
–BY VALERIE BARKER

45 PSYCHIATRIC AND SUBSTANCE ABUSE PEER REVIEW
This form of review has yet to find acceptance among Michigan physicians.
–BY RALPH WARD

47 HELPING THE ELDERLY MEET NON-MEDICAL NEEDS
A report by the MSMS Committee on Aging indicates that elderly patients need assistance in locating and gaining access to non-medical services — and physicians should get involved.
–BY JAMES G. O'BRIEN, MD

50 BOARD OF MEDICINE ACTIONS

Page 14

DEPARTMENTS

5 Reimbursement Roundup
7 MSMS "On The Move"
9 Newsfronts
10 Physicians in the News
53 Deaths
55 New Members
61 Meetings
63 Category I Courses
68 Classifieds
71 Advertising Index
72 President's Page
"Practice Parameters: A help or a threat to medical practice?"
BY ROBERT D. BURTON, MD

In next month's issue of *Michigan Medicine*:
Practice Management

Cover illustration by: *Robert L. Brent.*

Page 17

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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REIMBURSEMENT ROUNDUP

By Rose B. Heald
MSMS Reimbursement Ombudsman

Reimbursement Roundup addresses third party payer reimbursement issues affecting physician practices. The column appears every other month in Michigan Medicine and is prepared by staff in the MSMS Department of Medical Economics and Health Care Delivery. Suggestions for topics should be forwarded to the Department.

Payment for EKG Interpretation to be Eliminated

The Physician Payment Review Commission (PPRC) is urging Congress to repeal its ban on Medicare reimbursement of EKG interpretations, which is provided for in OBRA 90. The ban is scheduled to be effective January 1, 1992. Physician groups, including the AMA, are vigorously lobbying to get the ban repealed.

The PPRC believes that Medicare should continue to pay for EKGs separately from visits, but will examine alternative methods of bundling EKG, laboratory and procedural services with visits. Congress adopted the ban because it is anticipated the cuts will save $970 million from 1992-1996.

Sixty Percent Outpatient Pay Limit

Physicians who provide any of 282 HCFA-targeted services outside of the office will be paid only 60 percent of the amount they would normally receive if the services had been performed in their office. HCFA's reasoning is that physicians do not pay overhead expenses of hospitals or other sites outside their office. Hospital-based oncologists/hematologists will be hard hit by the cuts.

The HCFA list is not yet final and some procedures currently included may be eliminated. All services ultimately included will be implemented on a national basis and not subject to carrier discretion. The current list of procedure codes is only a guideline for carriers, and physicians may appeal a procedure on the list that is not routinely available in an office setting in their locality.

Durable Medical Equipment Requires New Medical Necessity Certificate

Physicians must complete a certificate of medical necessity for every piece of durable medical equipment (DME) they prescribe, effective September 1, 1991. Completing the form will be time consuming, since physicians will need to learn an entire new set of codes that describe each piece of equipment. Claims submitted without a properly completed certificate will be denied.

Certificates of medical necessity are required for hospital beds, wheelchairs, decubitus care mattresses, flotation and alternating pressure pads, oxygen, transcutaneous electrical nerve stimulation devices, seat-lift chair mechanisms, motorized scooters, prosthetics and orthotics, including parenteral/enteral nutrition.

Documentation may include medical records, plans of care, discharge plans and/or prescriptions. The physician must personally sign and date the certificate of medical necessity. Suppliers are prohibited from completing any of the certificate, except for the administrative portion of the forms.

UPIN Directories To Be Available Soon

Unique Physician Identification Number directories will be available to physicians by June 1991, according to HCFA. Claims submitted without the referring physician's UPIN will be denied, probably by the beginning of 1992.

The Michigan carrier assigned each physician a UPIN about a year ago. Purpose of the UPIN directory is to more easily enable the rendering physician to obtain the UPIN of the referring physician.

The UPIN requirement was adopted as a method to enable HCFA to track and control "overutilization" by individual physicians.

HCFA plans to make one directory available free to each billing entity, so a large group practice billing under a group identification number will receive only one directory. Additional copies will be available at minimal charge.

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MSMS On The Move

A MONTHLY UPDATE OF KEY MSMS ACTIVITIES

Liability MSMS, the Michigan Hospital Association (MHA) and the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS) set priorities in their campaign for legislative liability reform. The coalition agreed on priorities in the areas of limits on damages, statute of limitations and changing criteria for expert witnesses. These and other priorities are embodied in Senate Bill 248-249, the Michigan Alternative to create liability reform recently introduced in the Legislature. For a copy of the bill, contact Tom Wolff.

Communications MSMS conducted a media training workshop recently for physicians joining the Physician Communication Network. The workshop was held for physicians in Macomb, Oakland, and Washtenaw Counties. Physicians were taught the basics of how to communicate to the media and to the public. More workshops are planned for later this year as part of this continuing series which began in 1990.

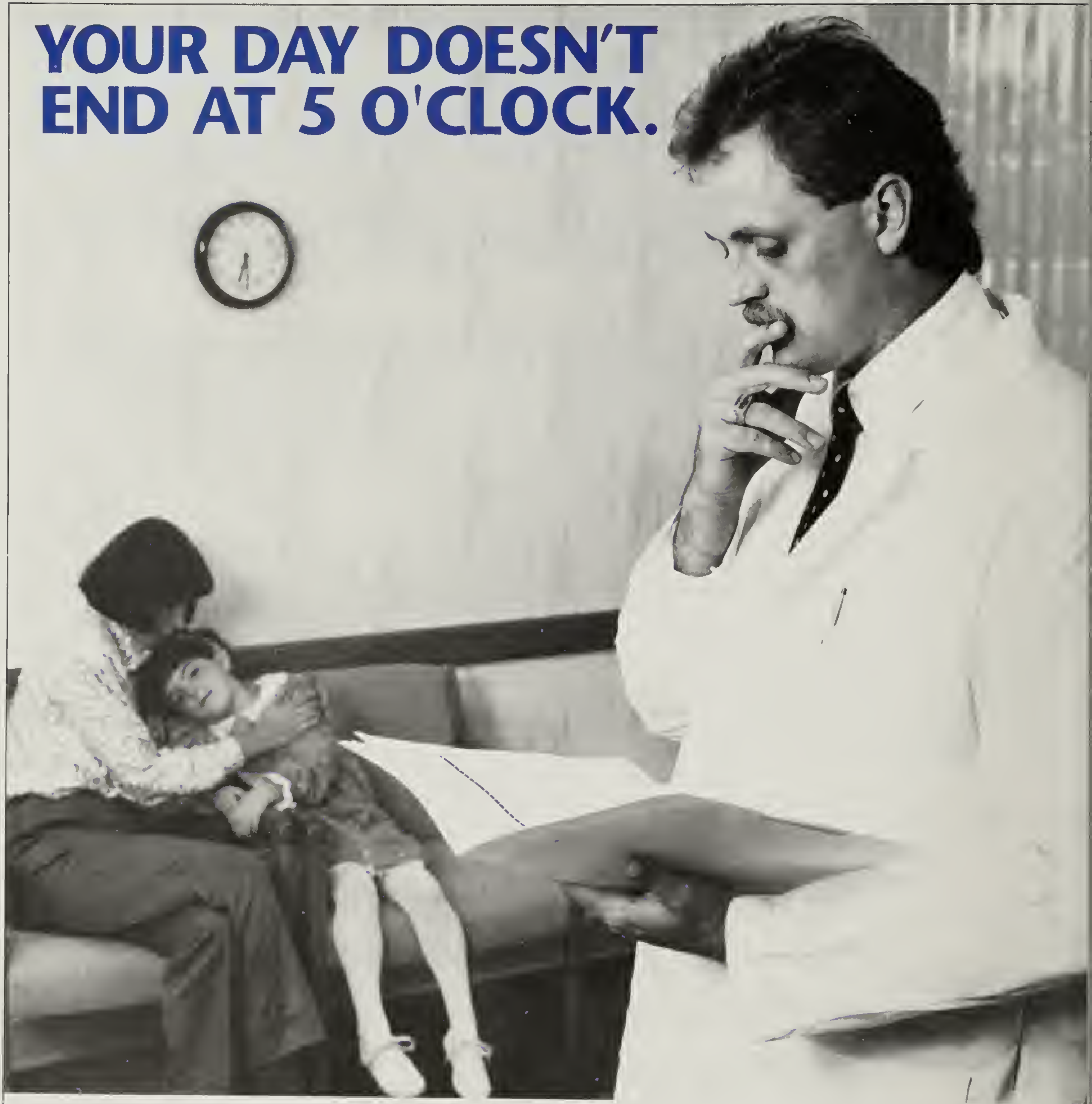
Durable Power of Attorney MSMS, in conjunction with the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS), the Michigan Hospital Association (MHA), and the State Bar of Michigan, began distribution of a durable power of attorney form to Michigan physicians and the public. The form was developed by the coalition following passage of Michigan's durable power of attorney law to help Michigan citizens determine in advance their health care wishes. Contact the MSMS Communications Department to order copies of the form.

Blue Cross Blue Shield of Michigan The 16-member BCBSM Physician Contract Advisory Committee will pursue study of payment and utilization in Michigan as a result of a recent meeting on physician reimbursement in Michigan. During that meeting a 1987 Blue Cross Blue Shield of America study comparing physician reimbursement in five neighboring states to that in Michigan was discussed. The Committee determined following a BCBSM explanation of the study that more detailed information is needed on physician payment and utilization in Michigan.

Workers Compensation MSMS recently established the Task Force on Workers Compensation chaired by MSMS Board member Richard P. Horsch, MD, Livonia to generate dialogue and action on workers compensation in Michigan. MSMS also is working to provide input on revisions to state workers compensation rules. MSMS members Paul R. Pomeroy, Jr., MD, Westland; Lawrence H. Handlesman, MD, Chelsea; and Lawrence G. Morawa, MD, Dearborn, recently were appointed to special task forces on the Michigan Department of Labor Advisory Committee on Workers Compensation. MSMS is soliciting specialty society representatives to sit on its task force. Contact Dan Farhat for details.

Day with a Doctor To help legislators better understand the rigors of a physician's professional life and issues important to them, MSMS and the Michigan State Medical Society Auxiliary have developed a program to pair legislators with physicians to explore a typical physician's day. As part of that "Day with a Doctor" program, Rep. Mary Brown (D-Kalamazoo) spent a day recently with MSMS member James W. Melluish, MD, Kalamazoo. Contact Tom Wolff for information on other "Day with a Doctor" sessions being planned in the coming months.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.



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MEDICAL NEWSFRONTS

INDEX

Michigan's infant mortality rate continues high 9

Riverview Hospital offers new program for brain injured/chemically dependent patients 9

Research reveals why mornings are hard on your heart 9

Bon Secours receives $450,000 training grant 10

Heritage Hospital expands rehab unit 11

U-M receives funding for wheelchair navigation project 11

Michigan Protection and Advocacy services awarded AIDS grant 12

Blacks must be cautious about high blood pressure 12

U-M performs 300th liver transplant 12

Michigan's infant mortality rate continues high

Michigan's infant mortality rate for 1990 is likely to be slightly lower than the rate for 1989, according to an estimate recently released by the Michigan Department of Public Health (MDPH).

Based on provisional data for 1990, it is estimated that the rate for 1990 will be 11.0 per 1,000 births, as compared to 11.1 for 1989. The infant mortality rate is based on the number of babies who die in their first year of life per 1,000 live births.

Overall, the statistics indicate Michigan's infant mortality rate is holding relatively constant for the fourth straight year. The lowest rate ever recorded in the state was 10.9 in 1987. This was followed by two years of small increases.

For the second year in a row, there has been a sharp increase in the number of live births in Michigan. There were an estimated 154,400 live births in 1990, a 4.2 percent increase over the figure for 1989. A rising trend in live births was first seen in 1989, when the number of Michigan live births went from 139,635 in 1988 to 148,164 in 1989. The number of live births in 1990 is the highest figures for Michigan since 1971, when 162,244 infants were born.

The two statewide estimates for 1990 births and deaths are the only two figures available now, health officials said. Additional statistics for 1990 will be ready and released this fall.

There appear to be several reasons for the lack of progress in reducing Michigan's high infant mortality rate, according to state health officials. First and foremost, new programs created in the eighties and aimed at improving access to prenatal care have not had an impact on the incidence of prematurity or low birthweight, which is the major cause of infant mortality.

"Early and comprehensive prenatal care is important because it helps a woman have a healthy baby," said MDPH Director Vernice Davis Anthony," but as a strategy in and of itself, prenatal care will never solve Michigan's infant mortality problem.

"More attention must be paid," she added, "to preventing maternal substance abuse and to reducing the growing numbers of high risk births."

Riverview Hospital offers new program for brain injured/chemically dependent patients

People suffering from traumatic brain injury (TBI) and chemical dependency can find help in a new interdisciplinary program at Beacon Center for Behavioral Medicine, Detroit Riverview Hospital.

The program, which opened in April, is one of the first of its kind in the country to focus on simultaneous treatment of this dual diagnosis. Offering a holistic approach, the program emphasizes a continuum of care services.

Consultant services are being provided by New Start Inc. of West Bloomfield. Roman Frankel, New Start's executive director, brings 20 years of experience in the field to Beacon Center's program. "Beacon Center's program will fulfill a great need locally for this complex disorder, " said Frankel.

According to Bill Peabody, director of the Beacon Center for Behavioral Medicine, studies have shown that "between 2,000 and 5,000 people in the metropolitan Detroit area each year experience traumatic brain injury plus a concurrent addictive disorder.

"Most of the time these concurrent diagnoses are blended and require special handling," Peabody adds. "Beacon Center's cognitively based program employs a staff cross-trained in traumatic brain injury, addictive and psychological disorders."

The interdisciplinary group of TBI/chemical dependency professionals includes: physicians, psychiatrists, nurses, social workers, occupational therapists, cognitive therapists, neuropsychologists, vocational specialists, recreational therapists, physical therapists, and case managers.

"The staff is trained to gently work with patients to achieve maximum physical, emotional, and spiritual recovery," said Peabody.

Research reveals why mornings are hard on your heart

For years, doctors have known more people die of heart attacks in the morning than any other time of day.

Now, new evidence indicates why.

"Several studies have shown cardiac deaths are twice as likely to occur between six a.m. and noon as at any other time of day," said Sidney Goldstein, MD, division head of Cardiovascular Medicine, Henry Ford Hospital, who is actively involved in that research.

In trying to discover the reasons behind the higher frequency of early morning deaths, researchers at Henry Ford Hospital studied platelets and found a major clue.

"We found that platelets are least active when people are lying down and most active when people assume an upright posture and begin their daily activities," said Syed M. Jafri, MD, of the division of Cardiovascular Medicine.

In addition to supporting the observation that there is a circadian rhythm to cardiac deaths, researchers at Henry Ford Hospital have demonstrated that the use of beta-adrenergic blocking agents often reduces the early morning peak in cardiac deaths among patients with

Continued on page 10

Continued from previous page

ischemic heart disease.

"A retrospective analysis of data collected during the Beta Blocker Heart Attack Trial found that 38 percent of patients who received a placebo experienced sudden death between 5 a.m. and 11 a.m., compared to 24 percent of patients who received beta blockers. In the remaining period of the day, the occurrence of sudden death was almost equal in both placebo and treatment groups," said Doctor Goldstein, who participated in the study.

Other physiological factors which may contribute to the preponderance of early morning deaths from heart attack include the tendency for heart rate and blood pressure to go up and for more adrenaline to be produced in the morning.

This new knowledge highlights the importance of proper timing in administering anti-heart attack medications, such as beta blockers, according to Doctor Jafri.

"One of the mechanisms by which these drugs may be working is by blunting this morning surge of heart rate, blood pressure, adrenaline and platelet activity. Our findings suggest that medications must be carefully timed so patients are protected in the early morning when they are most vulnerable to heart attack," he said.

Bon Secours receives $450,000 training grant

Bon Secours Family Practice Center, St. Clair Shores, has been awarded a three-year, $150,000 educational training grant from the United States Public Health Service, to benefit its Family Practice Center and increase service to patients.

As the first grant received in Bon Secours' 46-year history, it will be used to develop and implement a three-year pilot program utilizing a full-time psychologist and a part-time medical educator to teach practical methods about how the doctor should relate to the patient. The Bon Secours Foundation will administer the grant which will be funded from July 1, 1991 through June 30, 1994.

"Family medicine provides comprehensive care, covering a full-spectrum of health concerns for people of all ages. We view medical care as a "family issue," said Gerald Terlep, PhD, director of Behavioral Science at the Bon Secours Family Practice Center, and grant director. "This grant will allow our patients from Macomb and Wayne County to benefit from their taxes sent to Washington. A psychologist and a patient educator will be available to help our patients with their personal health problems.

Depression, anxiety, stress, addictive diseases, lifestyle changes, personal and family problems, and community referrals will all be treated at the Bon Secours Family Practice Center.

In addition to the direct services to patients, the psychologist will give educational lectures to physicians and will speak at community education programs sponsored by Bon Secours. The medical educator will work with physicians to provide several patient education groups with topics ranging from diabetes to high risk pregnancy, smoking, hypertension, weight management and more. The groups are designed to provide both technical and medical education for patients, as well as provide an opportunity for physicians to give direct medical advice to the patients as a group.

"Our goal is to integrate medicine with patient education," added Doctor Terlep. "This grant demonstrates one way that can

Continued on page 11

Physicians in the News

Chaim M. Brickman, MD, director, Lupus and Immunology Program, Sinai Hospital, Detroit, is a newly-inducted member of the American Lupus Society's Hall of Fame. Doctor Brickman was selected for his dedication to Lupus research and patient care.

Dewitt Burton, MD, was recently honored posthumously at the Detroit Urban League's Distinguished Warriors Dinner. Doctor Burton founded Detroit's first black hospital in the 1920s. Detroit Urban League honorees are distinguished physicians who have made measurable contributions as civil rights advocates.

Philip R. Glotfelty, MD, a Marshall surgeon, is recipient of the Silver Antelope Award, the highest honor given by the East Central Region of Boy Scouts of America.

James E. Graham Jr., MD, obstetrics and gynecology associate professor, Hurley Medical Center, Flint, is part of the Gynecologist Oncology Group leading the National Cancer Institute study to evaluate Taxol, a drug to fight ovarian cancer.

E. Dennis Lyne, MD, is the newly appointed director of the Orthopaedic Surgery Residency Program at MSU Kalamazoo Center for Medical Studies. Doctor Lyne is the former director of the Multidisciplinary Clinic and head of the Division of Pediatric Orthopaedic Surgery, Henry Ford Hospital.

Douglas McKeag, MD, professor and sports medicine coordinator, Family Practice, MSU College of Human Medicine, has been appointed a member of the Medical Advisory Board, 1996 Summer Olympics Committee.

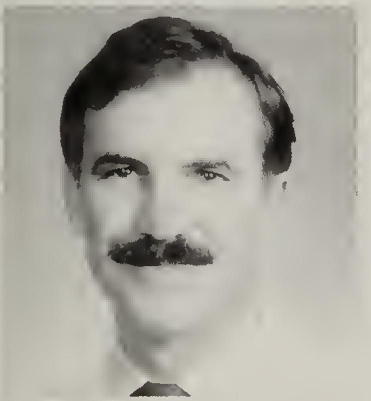
William D. Myers, MD, and **Mark H. Rubinstein, MD,** both Southfield ophthalmologists, are involved with a government study on the use of the Excimer laser in achieving the most technologically advanced skills available to the advancement of eye care. The laser was used for partial trabeculectomies on patients who were both medically and surgically uncontrolled. They had one of only three Excimer lasers in the US for their studies.

June Osborn, MD, dean of the University of Michigan School of Public Health, attended the Centers for Disease Control (CDC) conference in Atlanta on AIDS. Doctor Osborn has served as chairman of the National Commission on AIDS since 1989. She has been involved on the federal level with issuing guidelines and evaluating the risks of AIDS.

Ashok P. Sarnaik, MD, professor of pediatrics, Wayne State University School of Medicine, is the recipient of the 1991 President's Award for

Excellence in Teaching, an honor WSU bestows upon an individual who has demonstrated extraordinary teaching skills in his or her field of expertise. Doctor Sarnaik has been voted "Teacher of the Year" three times. His book, *Neonatal and Pediatric Intensive Care*, which he co-edited, is recognized as a standard text in the field. More than half of the pediatric critical care specialists in Michigan and many nationally have graduated from his training program.

D. Eugene Thompson, MD, Birmingham, is a newly-elected member of the board of directors of the American Academy of Orthopaedic Surgeons. Doctor Thompson is on staff at William Beaumont Hospital, Royal Oak, and Henry Ford Hospital, West Bloomfield.



Kevin K. Tremper, PhD, MD, is new professor and chairman, Department of Anesthesiology, University of Michigan Medical School. Doctor Tremper attended medical school at the University of California at Irvine. This was followed by a flexible internship and surgical ICU research fellowship at Harbor UCLA Medical Center. Doctor Tremper completed his residency in anesthesiology at University of California, Los Angeles in 1983 and came back to UC Irvine as a member of the faculty.

Vainutis K. Vaitkevicius, MD, a renowned cancer specialist and medical professor who once dreamed of being a concert pianist, has been named president of the Michigan Cancer Foundation. Known by many as "Dr. Vee," he also serves as chairman of WSU's internal medicine department, chief of medicine at Harper Hospital, and physician-in-chief of the Detroit Medical Center.

Kay H. Vydareny, MD, Ann Arbor, is newly-named president-elect of the Association of University Radiologists (AUR) for 1991-1992. Doctor Vydareny is currently assistant professor of radiology at the University of Michigan, Ann Arbor.

Frank B. Walker, MD, MSMS past president and current AMA Board member has been appointed a commissioner to the Joint Commission on Accreditation of Healthcare Organizations. He is corporate director of laboratories and a member of the Board of Directors of Detroit-Macomb Hospital Corp.

Douglas L. Wood, DO, associate dean of the Michigan State University College of Osteopathic Medicine, has been appointed dean of the college, effective July 1. The appointment of Doctor Wood, who has served as the College's associate dean since 1987, was approved by the MSU Board of Trustees in April. Doctor Wood succeeds Myron S. Magen, DO, the college's first and only dean, a position he has held since 1970. Doctor Magen will remain active with COM, leading the college's efforts in health policy analysis as it relates to the osteopathic profession. Doctor Wood said among his challenges are maintaining the college's record of training excellent primary care physicians, while "continuing to provide opportunities for women and minorities."

Continued from previous page

be done...by providing psychological, social, medical and educational support right in the doctor's office."

Heritage Hospital expands rehab unit

Heritage Hospital, Taylor, has expanded and remodeled its Physical Medicine and Rehabilitation Unit to meet the growing need for rehabilitation services in western Wayne County and the Downriver area.

The $500,000 renovation project, now complete, includes an increase in space for inpatient rehabilitation from 31 beds to 48 beds; a new state-of-the art rehabilitation apartment, where patients practice everyday skills needed in the home; and an expanded dining/activity room designed to be both functional and comfortable.

Heritage Hospital offers programs in physical, occupational, speech and hearing, and recreational therapies. Individuals in need of rehabilitation due to stroke, neurological disease, orthopedic problems, or oncology-related illness are treated by a team of rehabilitation specialists. Each patient has a care team, including the patient, the family, a board-certified physiatrist, a rehabilitation nurse, and a full range of other professionals.

The treatment plan at Heritage centers on a family-oriented approach. Family members are trained in rehabilitation techniques, along with the patient.

For more information, call (313) 295-5022.

U-M receives funding for wheelchair navigation project

The University of Michigan has received a four-year, $368,000 grant from the Veterans Administration Rehabilitation, Research and Development Service to develop and study an automatic navigation system for powered wheelchairs.

The project, headed by Simon Levine, PhD, director of the Rehabilitation Engineering Program at the U-M Medical Center, will study NavChair, an automatic assistance navigation system for power wheelchair control that will provide improved wheelchair maneuverability. The proposed system will utilize automatic obstacle avoidance in providing people with motor or sensory impairments to operate a power wheelchair more safely and effectively through a variety of environments.

The NavChair system uses ultrasonic transducers to avoid obstacles, allowing the user to move at high speeds in cluttered environments without fear of collision. For disabled persons unable to effectively steer a wheelchair straight, the NavChair also will be able to follow along a wall while ignoring unwanted changes in direction that would occur due to motor or sensory impairment.

The system is expected to permit automatic steering maneuvers around obstacles with only a slight decrease in speed. Other prototype systems bring a wheelchair to a stop when obstacles or collisions are present, then rely on the operator to steer around the obstacle.

The ultimate goal of the NavChair project is to transfer navigation technology developed for mobile robots to a power wheelchair. To facilitate the technology transfer for commercialization, this research will be performed in close collaboration with Everest and Jennings, one of the country's largest wheelchair manufacturers. The company will provide consultation and technical support and their most advanced power wheelchair to serve as the base for the NavChair system.

Michigan Protection and Advocacy Service awarded AIDS grant

Michigan Protection and Advocacy Service has been selected by the Council of Michigan Foundations as one of the grant winners from the Michigan AIDS Fund.

The Michigan AIDS Fund has allocated close to $500,000 for AIDS projects in the state of Michigan. Michigan Protection and Advocacy Service received a grant of $40,000 to support its work in helping communities respond to the problem of HIV.

"We are committed to helping people with HIV in our community," says Elizabeth W. Bauer, executive director of Michigan Protection and Advocacy Service. "This grant will enable us to provide critically important services. This investment today will help us respond to today's crisis and reduce tomorrow's crisis. AIDS was the second leading killer of men aged 25 to 44 by 1989 and will probably be among the top five killers of women in the same age group by the end of 1991," responded Ms. Bauer.

Blacks must be cautious about high blood pressure

Studies show that hypertension discriminates against blacks.

"Uncontrolled hypertension is a major public health problem in the United States that disproportionately affects African Americans," according to Susan Steigerwalt, MD, acting head, Hypertension Section, Henry Ford Hospital.

In fact, blacks are twice as likely as whites to develop hypertension. Some theories for this greater incidence include that blacks may have a hereditary predisposition to high blood pressure, or that socioeconomic disadvantages contribute. Other major risk factors for hypertension include sex, age and a family history of hypertension.

"Because of their greater susceptibility to hypertension, it's very important that African Americans make sure that they know what their blood pressure is and what it should be, and then do everything they can to control it," said Doctor Steigerwalt.

U-M performs 300th liver transplant

U-M Medical Center recently performed its 300th liver transplant, placing it among the top five liver transplant programs in the country. The 300 liver transplants performed at the U-M Medical Center since August 1985 have helped 261 people, including 36 who were transplanted twice and one who received four transplants. Almost 40 were babies and children.

The Medical Center made Michigan history in March 1990 when surgeons transplanted the lobe of a donor liver into a five month-old Detroit girl. The procedure, called a reduced-size liver transplant, was needed because the infant, suffering from biliary atresia, could not wait any longer for a pediatric liver.

"There's a great shortage of livers that will fit into small children, so we sometimes need to take half of an adult liver and transplant it into a child," said Robert M. Merion, MD, assistant professor of surgery and the transplant surgeon who performed the procedure. Since then, Doctor Merion and the transplant team have successfully done four more reduced-size liver transplants. ■

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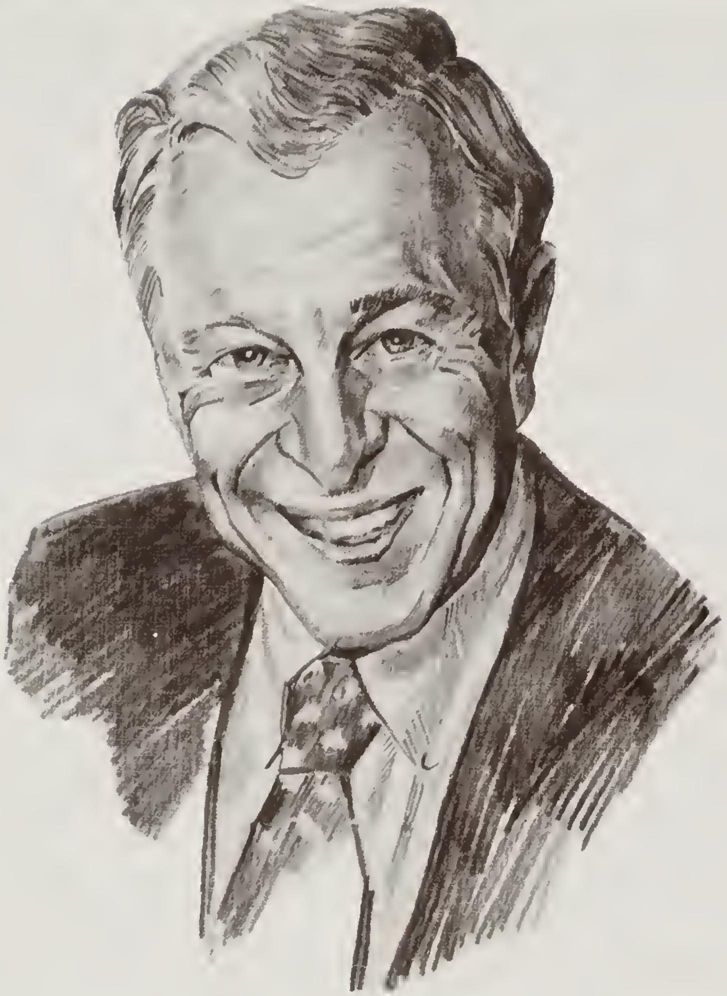

ROBERT D. BURTON, MD

An Active Advocate of Medicine

By Randall W. Braaksma

"Act your age." Robert D. Burton, MD, brings that phrase to mind but for exactly the opposite reason parents say it to their children. At 63, you'd expect Doctor Burton to be slowing down; instead, he's quickening the pace.

A look at his calendar provides a dramatic example of how the presidency of the Michigan State Medical Society is already affecting Doctor Burton's life. On his calendar for April you can see white spaces; on his calendar for May, his first as president, it's a solid tangle of pencil tracks.

Most of those are speaking engagements, and most of those are to county medical societies. What is Doctor Burton telling them? "It's my desire to have the 11,000 members of MSMS become advocates of the medical profession, and their 8,000 spouses too. That would give us 19,000 spokespersons for the profession."

The important issues facing medicine today — professional liability, medical ethics, government and third party payers, and Blue Cross/Blue Shield of Michigan issues — give physicians compelling reasons to become advocates. "The reality of the situation," says Doctor Burton, "is that if they don't become advocates there soon won't be a profession to advocate for."

Practicing otolaryngology for over 30 years has given Doctor Burton a valuable perspective on the changes occurring in medicine today. After graduating from the University of Michigan Medical School in 1953, Doctor Burton interned at St. Mary's Hospital in Grand Rapids. A residency at the U-M's Department of Otolaryngology and a stint in the US Air Force Medical Corps culminated in a Master of Science degree in otolaryngology from U-M in 1959.

From 1959 to 1961, Doctor Burton was affiliated with the Palo Alto Medical Clinic in Palo Alto, California. He also was a clinical teaching assistant at Stanford University, but the call of western Michigan was too strong for him to resist. In 1961, he opened a practice in otolaryngology in Grand Rapids.

An experienced advocate

Those years of experience give Doctor Burton's words an authoritative ring — he knows what he's talking about. He's also overcome what he calls the "in-born reluctance on the part of doctors to become visibly active." Perhaps the best example of this is his involvement with seat belt legislation in Michigan.

"I expend a lot of energy on promoting seat belt usage. I am chairman of the Michigan Coalition for Safety Belt Use. We've just had a news conference with the chief of police and others in Grand Rapids to launch a campaign we're calling *Buckle Up Grand Rapids*. Our goal for the campaign is to raise safety belt usage from 50 to 70 percent through increased awareness and increased enforcement of the seat belt law.

"We've started in Grand Rapids, but we will carry the program statewide. It will culminate with the introduction of legislation in Lansing later this year to make not wearing a seat belt a primary offense. Right now you have to commit some other violation, such as going through a red light, before an officer can stop you and, as a secondary matter, ticket you for not wearing your seat belt.

"Under primary enforcement, police officers can stop anyone who is not wearing a seat belt and for that reason only. In the areas that have primary enforcement, the compliance rate is between 85 and 90 percent. In the US, seat belt use still hovering around the 50 percent mark because of some of the weaknesses in the enforcement aspects, as well as in the educational aspect. Once people survive an accident by wearing seat belts, they become disciples, they are sold on it and they preach the value of wearing seat belts. It's been a gratifying thing. It's saved thousands of lives."

The gratification Doctor Burton and other members of the Coalition feel today compensates for the frustrations of the early 1980s when they worked to get seat belt legislation passed. "Those were discouraging days," recalls Doctor Burton. "I went to Lansing to the legislature almost every Wednesday. I got to know almost all the legislators while trying to convince them to support a seat belt law."

The Coalition's efforts paid off in 1985. "I feel very pleased that doctors got behind this legislation and helped make it law," Doctor Burton says. "This was a worthwhile, public health problem they wanted to tackle. They backed it 100 percent and it went through. It's an example of how physicians, when they are mobilized, can effect change."

An advocate for more than medicine

Being an advocate for seat belt usage makes sense for a doctor, who sees the value of avoiding serious injuries or death through the use of seat belts and the tremendous loss of wages and the rehabilitation costs which result when people don't. What is more surprising is the strength of Doctor Burton's advocacy in an area totally removed from medicine.

"Many doctors today are overworked, overburdened, and becoming fatigued with the picayunish details of running a practice, with all the rules and regulations that keep pouring down on them. Consequently, I feel every doctor should make opportunities for outside activities, recreation, a way to take a deep breath and enjoy himself or herself."

In Doctor Burton's case, these outside activities are many — from reading history to participating in archaeological digs, from buying wine futures to sampling the world's fine teas, from an every-other-day, brisk, four-mile walk with his wife to playing in a Dixieland band. Of these, music provides the most relaxing outlet.

"My parents bought me a trumpet so I could study classical music," Doctor Burton says. And he did, receiving a scholarship to the National Arts Academy at Interlochen. Then came World War II. "There weren't many musicians around," Doctor Burton recalls, "so I got a job playing jazz trumpet with *Red Working and His Trombone and Orchestra*. We played clubs in Saugatuck and Macatawa. I made nine to ten dollars a night and earned enough to pay my way through Hope College."

Red Working's influence on Doctor Burton continues today. A collection of photographs on the wall in Doctor Burton's office, affectionately known as the Rogue's Gallery, traces the history of his musical avocation, from a youthful Burton in a bold, vertically-striped tie seated next to Tommy Dorsey in the ballroom of the Waldorf-Astoria Hotel to an older, but still very fit Burton playing his trumpet in the Tailgaters band at the Schuss Mountain Jazz Festival.

There are other photos too, of Charles R. Henry, MD, playing trombone in his band the *Docs of Dixieland*. "You could say music brought us together," explains Doctor Burton. "Chuck was an intern at Blodgett when we played together in a gig. One thing led to another and in 1975 we became partners." In otolaryngology, that is. Competition between the two musicians remains fierce but friendly.

An advocate especially for medicine

That same competitive spirit and willingness to serve has involved Doctor Burton in many posts, including president of the Kent County Medical Society in 1977, chairman of the Michigan Delegation to the AMA, Speaker of the House for the MSMS House of Delegates for the past four years and a member of the House since 1974, and, since 1976, membership on the MSMS Committee on State Legislation and Regulation.

These posts have equipped Doctor Burton well for the role of advocate he will play as MSMS president, yet he is quick to point out the importance of all members. "I intend to encourage others who are sitting in their offices to get out and speak to the good of what medicine is really all about," he says. "If you get the doctors advocating their profession, you've got a force. If every person takes it upon himself or herself to be a spokesperson and become an advocate for the thing they know best, which is medicine, then we'll make progress.

"We can learn a lesson by looking at how health care has deteriorated in other countries. In Canada, England, and Germany, doctors let the government speak for them; in the process the entire health care system has deteriorated. We have some bad things about our health care system, there's no doubt about that; but if doctors work to improve these, we can make a difference. If they are reluctant to speak out and become apathetic, then we have a problem.

"Doctors have to go into discussion groups and committee meetings and the legislature and speak their piece. They have to write letters to the editor challenging articles that praise other health care systems, such as Canada's. Tell people that those who are writing articles for the big headline are not always giving the straight facts. We know what the facts are, we practice medicine every day. If anybody can speak for medicine, doctors ought to. They have to, because if they don't no one else will.

"The position of MSMS president has changed a lot in the last five years. It can no longer be a position of honor for a retiring physician. Today, he or she is a spokesperson for the profession." ■

Randall Braaksma is an East Lansing-based freelance writer.

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MPROVING THE QUALITY OF MEDICINE AND LIFE

MICHIGAN PHYSICIANS HAVE BEEN DOING BOTH SINCE 1701

By Herb Auer

Since 1700 there have been many accomplishments by medical doctors in Michigan — both in the fields of medical care and public service.

Twenty-seven books about Michigan were searched to identify and verify the 50 entries below. To tell the story of MDs in Michigan up through 1930, C. B. Burr, MD, Flint, physician and medical historian, needed 882 pages in his two volume *Medical History of Michigan* published by the Michigan State Medical Society.

This list, which begins in 1703 and runs through 1989, seeks to hit the highlights and also some of the more interesting happenings. The author first developed this list to accompany MSMS promotional kits mailed to all news media preceding Doctors' Day, March 30, 1991.

Anyone who has historical information to add to this list is encouraged to contact: Herb Auer, 6273 Summit Ct., Traverse City, MI 49684.

See pages 19, 21 and 23 for more historical information on MDs in Michigan.

1701

Henry Belisle "seems to have been Detroit's first physician and surgeon," according to medical historians. His father was a druggist in France and he studied medicine there. It is rumored that he came with the Cadillac party. In 1712 he moved to Montreal.

1720

Jean Baptiste Chapoton arrived at Fort Pontchartain du Detroit from France as the garrison surgeon. He resigned from the French army in 1751 and remained in Detroit — the only French doctor to do so. Several descendants also were early Detroit physicians.

1760

George Christian Anthon came from Germany to Detroit. He served the French garrison and cared for the citizenry and the Indians. After a period in New York he returned in 1767 as surgeon to the Indians and later as surgeon of the garrison, a second time.

1781

William Harfy, a surgeon came to Detroit in 1781 and remained until the American possession of Detroit in 1796.

1796

William McCoskry, formerly of Carlisle, PA, came to Detroit as the first of the American Garrison Physicians. In 1803 he began a private practice in Detroit.

1819

Marshall Chapin was appointed by General Lewis Cass as the American Garrison Doctor in Detroit. He served until 1838. He had been one of the signers of the articles of incorporation of the Territorial Medical Society in 1820. He was mayor of Detroit in 1833.

Five doctors met in Detroit and organized the first medical organization, the Michigan Medical Society "to examine persons and certify those so deemed as doctors." At that time there were eight doctors in Detroit and "scarcely more in the Territory." The society disbanded in 1851.

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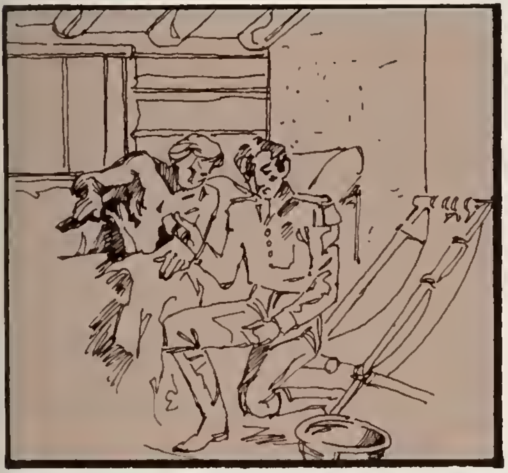
1822

William Beaumont, doctor at the fort on Mackinac Island, started his famed observations of the digestive process on June 6, 1822, when Alexis St. Martin, 18, was wounded in the abdomen by an accidental gunshot. His wound healed, leaving, however, a permanent gastric fistula an inch in diameter. For 11 years Doctor Beaumont conducted experiments observing the digestive process. His book in 1833, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion" was hailed internationally as a breakthrough.



1832

Detroit physicians provided care for many early settlers at the Wayne County Poorhouse, which housed the sick poor, sick orphans and so-called insane vagabonds. This facility later was known as the Wayne County Infirmary and the Psychiatric and General Hospital at Eloise.

1834

Douglass Houghton, famed for his later geological studies of Copper and Iron in the Upper Peninsula, was one of the valiant physicians who served during the Asiatic cholera epidemic that claimed 122 persons in a 20-day period. In 1837 he was appointed the state geologist, but drowned at age 36 in a storm off Eagle Harbor in 1845.

1842

Zina Pitcher, Detroit, received major credit as being instrumental in the adoption of an act which established the first absolutely free system of education in Michigan. He served a number of terms as president of the Medical Society of the Territory of Michigan.

1845

The nuns at St. Anne's, at Larned and Randolph in Detroit, turned a long building into a hospital and called it St. Vincent's Hospital — and later changed its name to St. Mary's Hospital. St. Vincent was the only hospital in the Northwest Territory when it opened.

1850

The University of Michigan Medical School was established in Ann Arbor. The first faculty included Doctors Silas H. Douglas, Zina Pitcher, and Moses Gunn, with Doctor Sager as the first dean. Sager served as dean for a quarter of a century.

1852

John Harvey Kellogg, born February 26, 1852, invented granola, wheat flakes and other foods, and an electric light cabinet for heat treatment that was exhibited at the Chicago Exposition in 1893 and in Germany. A biographer of Doctor Kellogg, who trained at Bellevue Hospital Medical School, wrote, "He fought the good fight against alcohol, tea and coffee, tobacco and meat..." Doctor Kellogg died at age 91.

1853

The second state medical organization, the Peninsular Medical Society was formed in Ann Arbor, March 30, 1853, primarily "for the advancement of medical science." The society disbanded in 1860 largely because of national unrest and the Civil War. (See 1866)

1856

Physicians came to Detroit from across the nation to the first AMA meeting ever held in Michigan. Zina Pitcher was elected the AMA president.

1856

H. D. McCulloch, part-time physician and storekeeper in St. James on Beaver Island, allegedly was one of two disgruntled followers who ambushed King James Jesse Strang at close range with their muskets.

1859

The Michigan Asylum for the Insane opened in Kalamazoo marking the first shift of responsibility from local to state for the insane.

1861-1865 Civil War

Many Michigan physicians served in the Civil War. The Medical History of Michigan, Volume II, carried factual information about almost 300 Michigan MDs on 71 pages. After the War, two surgeons Josiah Andrews of Paw Paw and Foster Pratt of Kalamazoo returned to their Michigan practices and were elected to the Michigan legislature — Andrews in 1846 and Pratt in 1858. Civil War records show that five times as many soldiers on both sides died of disease as of wounds.

1866

On June 5, 1866, after the Civil War was over, the physicians decided to reorganize and about 100 doctors traveled from across the state to Detroit to organize the Michigan State Medical Society in the Detroit IOOF Hall on Woodward between Congress and Larned.

1866

Cyrus M. Stockwell, Port Huron, was elected June 5, 1866, as the first president of the Michigan State Medical Society, followed by J. H. Jerome, Saginaw; William H. DeCamp, Grand Rapids; Richard Inglis, Detroit; and other doctors from big and small cities and the Upper Peninsula.

1867

Samuel Duffield started making drugs over his Detroit drug store and soon was joined by partners Harvey C. Parke and George S. Davis. Doctor Duffield withdrew from the firm, which became the Parke, Davis and Company.

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1868

Edward W. Jenks was the first president of the faculty when the Detroit Medical College was established. Wayne State University School of Medicine, which took that name in 1934, dates its history back to the 1868 date.

1869

The nation's first "university hospital" was established by The University of Michigan. Doctors there were the first to use the EKG machine, gastroscope, fluoroscopy. The department of dermatology was the first ever.

1873

The State Department of Health was established, the fifth in the young nation.

1886

Henry B. Baker, secretary of the State Board of Health for many years, was successful to get the State Board to establish a Hygienic Laboratory at the University of Michigan — the first of its kind in the nation. He is regarded as the "father of public health in Michigan."

1873

Robert C. Kedzie joined the Michigan Agricultural College faculty, and gained fame later when his research proved arsenic-laden paris green wallpapers were being sold and used. This deadly wallpaper passed out of use. He was president of the Michigan State Medical Society in 1875.

1873

The State adopted Public Act 81 which established the State Board of Health "to supervise the interests of health and life of Michigan citizens."

1874

St. Mary's in Saginaw, established in 1874, and Mercy Hospital at Big Rapids in 1879 were among those built to care for lumberjacks.

1881

Anna S. Rankin was the first woman to graduate from the two-year program at the Michigan College of Medicine and Lucy J. Utter was graduated in 1882. Seven women had been admitted to that class.

1883

For the first time the new Medical Practice Act required physicians to register. The legislation was strongly endorsed by the Michigan State Medical Society.

1885

The Upjohn Company was founded in Kalamazoo by William E. and Henry U. Upjohn, and later joined by two younger brothers Frederick and James. The firm began as the Upjohn Pill and Granule Company. The four physicians were sons of Uriah Upjohn, who practiced in Richland, northeast of Kalamazoo. Henry and James began practice in Kalamazoo, William in Hastings. It was William who invented the "friable pill" which could be crushed under the thumb.

1885

James Decker Munson, 1873 graduate of the University of Michigan Medical School, was appointed medical superintendent in 1885 of the new Northern Michigan Asylum in Traverse City. In 1915 the city's only general hospital burned and Doctor Munson offered an apartment building on state grounds for a general hospital. Fifteen doctors formed the staff. A hospital was erected in 1955, enlarged several times and today has a staff of close to 200.

1898

One Spanish American War list includes these surgeons who served as majors — Andrew P. Biddle, Detroit; Lawrence D. Knowles, Three Rivers; Charles B. deNancrede and Victor C. Vaughan of Ann Arbor; Henry D. Thomason, Albion; James A. King Manistee; and Oliver P. Barber, Saginaw.

1905

The Michigan Legislature created a State TB Sanitorium Act, and the first one was erected in Livingston County.

1914-1918 World War I

Many physicians joined medical companies and served valiantly in World War I. Many rose in ranks and received special honors, and some of them were killed in action. To single out one, Angus McLean was president of Wayne County Medical Society in 1910 and practiced surgery at Children's, Providence and Harper Hospitals. While commanding officer of a base hospital in France, he helped develop the serum "that defeated tetanus." He was assigned as the personal physician to President Wilson at the peace conference in Paris in 1919. He died in 1939.

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1917

Bertha Van Hoosen, a graduate of the University of Michigan Medical School in 1888, interned at Detroit Women's Hospital and was a staff physician at the Kalamazoo State Asylum, was installed in 1917 as the first president of the American Medical Women's Association. Her obituary in Time magazine described her many years as a prominent obstetrician in Chicago and as an early advocate of sex education.

1923

Reuben Kahn developed the famous Kahn diagnostic test for syphilis at the Michigan State Health Department laboratory. Later at the University of Michigan Medical Center, Doctor Kahn and associates developed a new laboratory method of diagnosing multiple myeloma.

1930

Grover C. Penberthy, U-M graduate in 1910 and chief of staff and chief of surgery at Harper Hospital, gained worldwide acclaim in 1930 for perfecting the use of tannic acid for burns caused in industrial accidents. There is a Grover C. Penberthy Pavilion at Children's Hospital. A past president of the Wayne County Medical Society, he was president of MSMS in 1935-36.

1943

Marjorie Peebles Meyers was the first black woman to be graduated from the Wayne State University School of Medicine. In recognition of her services to patients, the medical profession and the community, she received the MSMS "Outstanding Physician in Michigan Award" in 1968.

1952

Forest D. Dodrill, Edward Hill and Robert Gerisch, all at Harper Hospital, perfected a new type of mechanical heart and used it on a human patient to pump the patient's blood around his heart. General Motors Corporation was a partner in the project. The so-called "Michigan Heart" is on permanent display in the Smithsonian Institute, Washington, DC.

1954

Otto O. Beck, MSMS president in 1951-52, led the MSMS efforts to finance and design the Beaumont Memorial, which was dedicated on July 17, 1954. Thousands visit the Memorial each summer at Mackinac Island, near where Doctor William Beaumont conducted his medical breakthrough research on the digestive tract and gastric juice.

1955

Thomas Francis, Jr., at the University of Michigan on April 12, 1955, announced, "It works" after a nationwide test which established the value of the polio vaccine. Doctor Jonas E. Salk, who studied and taught at the U-M School of Public Health 1952-57 had perfected the vaccine to prevent paralytic polio.

1960

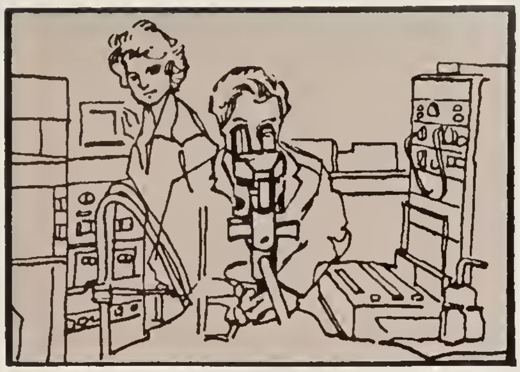
Butterworth Hospital doctors in Grand Rapids began to offer ambulatory surgery.

1964

Andrew H. Hunt became dean of the new Michigan State University College of Human Medicine during its two-year school phase and for the four-year medical school. A pediatrician, he provided the leadership of the MSU college which now graduates a class of 100 students per year.

1972

On May 7, Wayne State University dedicated the Gordon H. Scott Hall of Basic Medical Science in the 240-acre medical complex which included four major hospitals, WSU medical research building and WSU medical library. Doctor Scott, a PhD in anatomy, was named dean in 1954, and was instrumental in planning the medical center with planning starting in 1954. He was appointed vice-president for medical development in 1951.



1986

John J. Coury, Port Huron surgeon, was elected president of the American Medical Association after providing strong leadership to the AMA Board of Directors and House of Delegates. He was the MSMS president in 1972.

1987

Charles H. Wright, an obstetrician on the staffs of Hutzel, Harper, Grace and Southwest Detroit hospitals, was the originator and moving force behind the Detroit Museum of African American History, which opened in 1987. He got the idea when returning from a civil rights march in Selma, Alabama. He has been honored by the Michigan State Medical Society, The Detroit News and other groups.

1989

Charles F. Whitten was received at the White House by President Bush to recognize his leadership in founding the National Association for Sickle-Cell Disease and for alerting national policy leaders to that disease. In 1955, he came as a fellow in pediatrics at Children's Hospital and joined the WSU School of Medicine in 1956. He is director of the WSU Sickle Cell Center, reported to be one of few in the nation.

Persons interested in Michigan medical history are invited to help add to this historical article about prominent Michigan physicians by sending clippings, journal articles and personal recollections about important MDs to Betty McNerney, Editor of Publications, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

This list was compiled from a review of books and with the assistance of several sources of MD information. ■

Herb Auer had been associated with Michigan Medicine for 20 years before leaving MSMS for The Michigan Health Council in 1979.

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A MESSAGE TO AUXILIANS

MSMS and MSMSA must work together, says Lois Germain Duhamel

Editor's note: Lois Duhamel was inaugurated as president of the MSMS Auxiliary May 1, 1991. Following is her address in its entirety.

I'd like to take this opportunity to thank Pat Dolan for her outstanding leadership as president of the Michigan State Medical Society Auxiliary. This past year the Auxiliary has been faced with special challenges, but with Pat's example and encouragement, and a supportive board, we have just completed a very successful year. I know the 1991-92 board and all our membership will continue to give me the support that I will need to keep our Auxiliary moving ahead in this increasingly difficult time facing organized medicine. It's especially reassuring to know that Pat will be there with her expertise when we need it.

As the practice of medicine is constantly changing in today's world, so too is the Auxiliary. No longer are we just a social group acting as a support group for the medical family. We are actively working with and for the medical family. We are actively working with and for the medical societies on the national, state and county levels, in the legislative arena, sponsoring health-related programs (on drug abuse, teenage pregnancy, alcoholism, AIDS, etc.), fundraising for medical education, and numerous other health-related projects. We as auxilians are involved in all kinds of community projects. We are the extension of the physicians in our communities. Through these activities, we can and must improve the image of the doctor.

In the political arena we must become informed on issues and candidates especially as they affect the practice of medicine. Physicians are busy people and usually not very politically astute. Auxilians are busy people also. But we must find time to be active and informed in these matters, so we can help enlighten our spouses and families who are also voters. Many doctors are not registered to vote, and many who are registered do not take the time to vote. Voting is a privilege and a duty that all citizens should exercise.

It is important for auxilians to become acquainted on a first name basis with their local, county and state legislators. This can be done easily by attending civic meetings such as legislative breakfasts, luncheons, League of Women Voters meetings, and other functions. However, the best way for a legislator to get to know you personally is for you to become actively involved in his or her political campaign as a volunteer. Becoming a volunteer need not involve a large commitment of time or money, but the rewards are substantial. The most important benefit is that the auxilian can become the contact person with this particular legislator regarding the many urgent issues that affect medicine and how it is practiced in Michigan. The voice of medicine must be heard not as being self serving but rather as speaking for the patient's well being and the quality of care. The relationship with the legislator may not produce positive results immediately, but will require diligent fertilizing and cultivating in order to produce a bountiful harvest in the future.

As membership chairman this past year, I stressed membership retention as a prime goal, followed closely by recruitment of new members. I wrote a personal letter to the presidents of all county medical societies in Michigan, stressing the importance of Auxiliary participation at the county level. I asked them to encourage their members to stress this importance to their spouses. The county Auxiliary should function as the right arm of the county medical society, especially in public relations, charitable fundraising, patient education, and of course, political action.

More members needed

An active Auxiliary can help retain and boost membership in the medical society. We all know Auxiliary membership has been in a decline. This trend must be reversed. I call on each and every one of you to go back to your county and interest another physician's spouse who is not a member to attend your next Auxiliary meeting, and to become involved in the Auxiliary. The very future of our organization depends on bringing in fresh blood. We need a transfusion of new members and this can only be accomplished through personal contact at the local "grass roots" level — the county.

We have a busy year ahead of us. I need the active support of all of you if we are to make a significant impact on these vital issues. The Michigan State Medical Society and the Michigan State Medical Society Auxiliary must function as a true partnership if we are to stand ready to meet these challenges facing medicine in the '90s. Let's show that Michigan doctors' spouses care! If we don't, who will?

Lois Duhamel is MSMSA president.

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MSMS Members Should Enroll Now in the Delta Dental Plan

By Valerie Barker

MSMS members, their families and employees will be able to enroll in the Delta Dental Plan of Michigan sponsored program until June 30. Only groups of two or more subscribers will be allowed to enter the Plan during the remainder of the year. Coverage for new subscribers who apply during "open enrollment" becomes effective July 1.

The Delta Dental Plan was introduced to MSMS members in 1988, and has grown considerably since then. Currently, 1,200 MSMS member physicians and their employees are covered through the Plan.

The following premium schedule will be in effect until June 30, 1992. All premiums are invoiced in advance on a quarterly basis.

One Person Rate	$28.55/Monthly
Two Person Rate	$52.00/Monthly
Family Rate	$86.30/Monthly

The chart at right provides further details on eligibility and enrollment, payment, cost, and administration. The chart also provides a detailed list of covered services.

For additional information about the Plan, contact one of the MSMS Group Insurance service representatives at 1-800-748-0195.

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MSMS members, their dependents, employees and their dependents, and eligible surviving spouses may enroll in the Delta Dental program during June of each year. New MSMS members and employees or groups of two or more subscribers may enroll at any time. Participation in other benefit programs through MSMS is not required, nor do all employees have to enroll in the program. However, subscribers are required to remain enrolled for a minimum of twelve consecutive months. Persons previously enrolled in the program who requested cancellation or were terminated are not eligible for enrollment.

PAYMENT

Ninety percent of Michigan's dentists are contracting with Delta. This means that Delta's payments and patients payments if any are to be accepted by the contracting dentist as payment in full. Subscribers will be responsible for full payment to the non-contracting dentist. (Should services be rendered by an out-of-state dentist, Delta will make payment to the subscriber based on the dentist's fee or the usual, customary and reasonable fee of a contracting Michigan dentist, whichever is less.) Delta's payment is sent directly to the contracting dentist.

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ADMINISTRATION

The Delta program is administered through the MSMS Group Insurance Trust. Service Representatives are available via 1-800-748-0195, a national toll-free telephone number, Monday through Friday, to answer questions. Claims are paid by Delta to the participating dentist or in some cases directly to the subscriber.

The following chart indicates the services covered by Delta Dental Plan of Michigan through the MSMS sponsored dental benefits program. It also shows the percentage of coverage of the contracting dentist's usual/customary fee for each category and your copayment, if any:

	Delta Pays	You Pay
DIAGNOSTIC Includes oral examinations and emergency palliative treatment.	100%	0
PREVENTIVE Includes prophylaxes and topical applications of fluoride solutions.	100%	0
RADIOGRAPHS As required, and in conjunction with the diagnosis of a specific condition requiring treatment.	100%	0
ORAL SURGERY Includes extractions and other oral surgery procedures usually employed by a dentist, including pre- and post-operative care.	50%	50%
RESTORATIVE Includes amalgams (silver fillings), synthetic porcelain, plastic restorations, relines and repairs to prosthetic appliances. Gold restorations, crowns and jackets may be used, but only when the teeth can't be restored with another filling material.	50%	50%
PERIODONTICS Procedures usually employed by a dentist for the treatment of diseases of the gums and supporting strctures of the teeth.	50%	50%
ENDODONTICS Procedures usually employed by a dentist for the treatment of non-vital teeth (i.e., root canals).	50%	50%
PROSTHODONTICS Includes procedures for the construction of bridges, partial and complete dentures.	50%	50%
ORTHODONTICS Treatment and procedures required for the correction of malposed teeth. Eligible persons are covered *only* to age 19.	50%	50%

BENEFIT MAXIMUMS

The maximum dollar amount this plan pays during each contract year for each covered person is $1,000. For orthodontic care, the plan pays a *lifetime* maximum of $1,000 for each eligible person.

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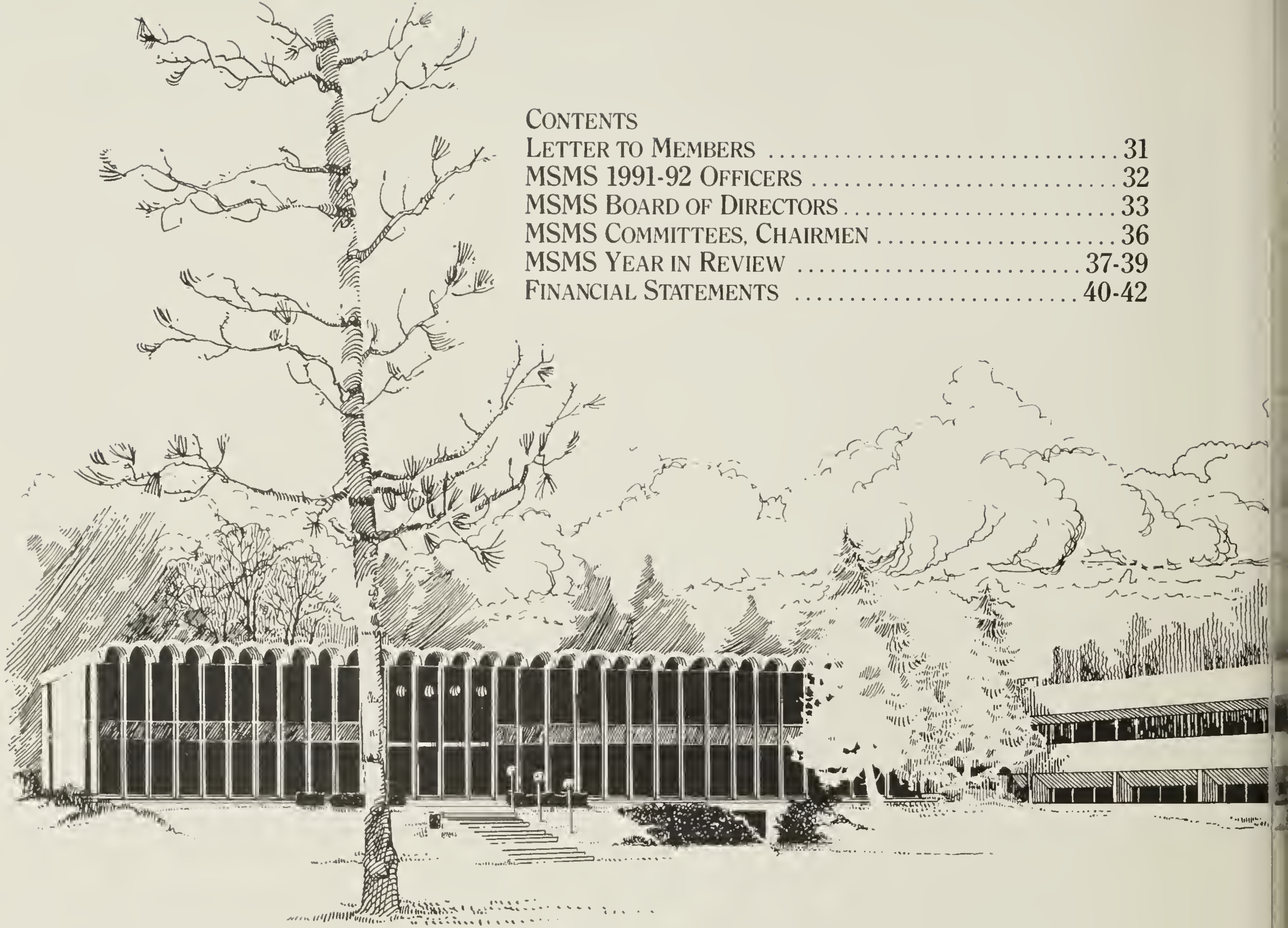
AIR FORCE

MICHIGAN STATE MEDICAL SOCIETY ANNUAL REPORT 1990-91

Saluting 1991-92 MSMS leaders,
and reviewing the year's progress.

CONTENTS

LETTER TO MEMBERS 31
MSMS 1991-92 OFFICERS 32
MSMS BOARD OF DIRECTORS 33
MSMS COMMITTEES, CHAIRMEN 36
MSMS YEAR IN REVIEW 37-39
FINANCIAL STATEMENTS 40-42



Architect Minoru Yamasaki created a building of unusual design and unique construction to house the Michigan State Medical Society. Combining elegance with utility, the structure's timeless style belies its 1959 construction.

The building stands on an elevation surrounded by three-and-one-half acres of beautifully landscaped grounds. Its 31 gracefully curved, 55-foot-long vaults of pre-cast concrete rest on 64 vertical columns. The columns and side walls are made of quartz aggregate surface concrete. Nearly 80 percent of the exterior of the building is gray non-glare glass. The main structure is 155 feet long, 46 feet wide, and encloses 20,000 square feet of floor space.

A circular drive off Saginaw Street offers access to the raised terrace extending the full length of the building. The off-center front entrance is recessed and opens into a two-story high reception area.

Behind the building, terraced steps rise from the large parking lot to the main entrance. Sheltered by large trees, the rear of the structure is equally imposing as the front.

LETTER TO MEMBERS

WILLIAM E. MADIGAN
Executive Director

In this 125th year of the Michigan State Medical Society, it is more imperative than ever that individual physician members become involved in the activities of MSMS.

Medicine is seemingly under attack on all fronts. Cost containment. Peer review. Third-party payers. Medicaid cuts. Professional liability.

As an organization, MSMS is representing physicians on all of these issues, and more.

But MSMS is only as strong as the dedication and willingness of the individual physician to sacrifice time, energy and effort to the realization of MSMS goals. By serving the greater good, individuals serve themselves.

There is no better example of this than the current struggle for professional liability reform.

MSMS has joined a unique coalition with the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons to press for significant tort reform and an alternative dispute resolution system for handling professional liability claims. In an effort to bring as much pressure on the legislature as possible, we are working to bring other organizations into this coalition: businesses, chambers of commerce, consumer groups, local governments, senior groups and unions.

Real pressure for change in the legislature, however, comes from the grassroots up.

Real pressure for change will require one-on-one contact with legislators from individual members of each of the coalition members. The most effective contact is face-to-face. If that's impossible, a telephone call or a letter nudges legislative action.

Physician leaders of MSMS have made professional liability reform a top legislative priority for the next one to two years. Throughout this period, they will be calling on all MSMS members to make those one-on-one contacts with legislators.

MSMS as an organization is doing everything possible to set the stage for professional liability reform.

Its success lies almost entirely in the hands of the individual physician.

Saluting 1991-92 Officers

Robert D. Burton, MD
President

Doctor Burton, *a Grand Rapids otorhinolaryngologist, is chairman of the Michigan Delegation to the AMA, past president of the Kent County Medical Society and currently serves on the MSMS Committee on State Legislation and Regulation, the Legislative Committee of the MSMS Board of Directors and the Committee on Member Services. Doctor Burton has served as Speaker of the MSMS House of Delegates and has been a member of the MSMS Board of Directors since 1982. He is a graduate of the University of Michigan Medical School.*

Thomas C. Payne, MD
President-Elect

Doctor Payne, *a Lansing diagnostic radiologist, is former MSMS assistant secretary. A graduate of the University of Cincinnati School of Medicine, Doctor Payne is a member of the MSMS Medicaid Liaison Committee and the MSMS Task Force on Professional Liability. He is an alternate delegate to the AMA and past chairman of MDPAC.*

Susan H. Adelman, MD
Immediate Past President

Doctor Adelman, *a Detroit pediatric surgeon, is chairman of the MSMS Task Force on Environment and Health and of the MSMS Focus Group on Chemical Dependency. She is a member of the MSMS Committee on Bioethics, former chairman of the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan; immediate past chairman of the Wayne County Medical Society Board of Trustees; past president of the Wayne County Medical Society; and editor of the* Detroit Medical News. *A graduate of the Wayne State University School of Medicine, Doctor Adelman is a delegate to the AMA, serves on the AMA's Women in Medicine Advisory Committee and is chairman-elect of the AMA Surgical Caucus.*

Thomas R. Berglund, MD
Secretary

Doctor Berglund, *a Portage family physician, is past MSMS president and Board chairman. A graduate of the University of Michigan Medical School, Doctor Berglund is past chairman of AMPAC and currently serves as president of the Michigan Physicians Mutual Liability Company.*

Billy Ben Baumann, MD
Treasurer

Doctor Baumann, *a Pontiac clinical pathologist, is vice chairman of the Michigan Delegation to the AMA; president of the Board of Directors, Physician Service Group, Inc.; member of the Board of Directors, Michigan Physicians Mutual Liability Co.; and past president of the Oakland County Medical Society and the Michigan Society of Pathologists. He is a graduate of the Washington University School of Medicine, St. Louis.*

Robert D. Allaben, MD
Speaker

Doctor Allaben, *a Detroit surgeon, is a delegate to the AMA; chairman of the MSMS Task Force on AIDS Education; member of the MSMS Committee on MSMS Policy and the Committee on Constitution and Bylaws; president-elect of the Organ Procurement Agency of Michigan and is a member of the Board of Trustees of the Transplantation Society of Michigan. A past president of the Michigan Chapter of the American College of Surgeons, Doctor Allaben is a graduate of Wayne State University School of Medicine.*

Gary D. Maynard, MD
Vice Speaker

Doctor Maynard, *a Kalamazoo anesthesiologist, is an alternate delegate to the AMA; member of the MSMS Task Force on Professional Liability and the MSMS Liaison Committee with MPRO; past chairman of the MSMS Hospital Medical Staff Section; vice president of medical services, Bronson Healthcare Group, Inc.; past president, Michigan Society of Anesthesiologists; director, American Society of Anesthesiologists; and chairman, MSMS Liaison Committee with BCBSM. He is a graduate of the University of Michigan Medical School.*

Donald K. Crandall, MD
AMA Representative

Doctor Crandall, *a Muskegon general surgeon, is past president of MSMS. A graduate of the University of Michigan Medical School, he is a member of the Michigan Delegation to the AMA and is a member of the AMA Council on Medical Service, for which he served as chairman in 1987-88. He also served on the Steering Committee for the Development of the AMA Health Policy Agenda, and on the AMA Physician Payment Task Force. He is a member of the MSMS Liaison Committee with BCBSM and the MSMS Medicaid Liaison Committee.*

Board of Directors

Jack L. Barry, MD
Chairman

Doctor Barry, *a Saginaw family practitioner, is chairman of the MSMS Board of Directors. He also is MSMS Board representative to the MDPAC Board. A graduate of the Wayne State University School of Medicine, he is a member of the Board of Directors, Health Plus of Michigan and serves as a medical director for Health Plus.*

W. Peter McCabe, MD
Vice Chairman

Doctor McCabe, *a Grosse Pointe Woods plastic surgeon, has held a variety of posts with MSMS and other professional organizations including vice chairman of the Physicians Insurance Company of Michigan. A past president of the Wayne County Medical Society, he earned his medical degree from Cornell University.*

Robert W. Black, MD, *a Detroit internist, is chairman of the Board of Directors, Michigan Health Care Education Research Foundation and is vice chairman of the Board of Directors, Blue Cross Blue Shield of Michigan. A past president of the Wayne County Medical Society, Detroit Academy of Medicine and the Detroit Medical Club, he received his medical degree from McGill University, Montreal.*

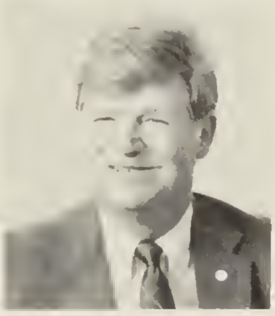
Cathy O. Blight, MD, *a Flint pathologist, is president and member of the Board of Directors of the Michigan Society of Pathologists and is president-elect of the Genesee County Medical Society. Doctor Blight is a delegate to the College of American Pathologists' House of Delegates and an alternate delegate to the AMA for MSMS. She is a graduate of the Michigan State University College of Human Medicine.*

Gilbert B. Bluhm, MD, *a Troy rheumatologist, is chairman of the MSMS Advisory Committee on Medical Economics; advisor to the MSMS Medicaid Liaison Committee; the MSMS Task Force on Professional Liability, the MSMS Liaison Committee with BCBSM, the MSMS Committee on Membership Recruitment and Retention and the MSMS Committee on Medical Licensure and Discipline. An alternate delegate to the AMA He received his medical degree from Indiana University.*

R. Jack Chase, MD, *a Grand Rapids internist, is former chairman of the MSMS Committee on Cost Containment, and is a board member of MDPAC. A delegate to the AMA, he is a member of the board of trustees at the Butterworth Foundation and Butterworth Hospital. He is a graduate of the University of Michigan Medical School.*

Henry M. Domzalski, MD, *a Detroit urologist, is chairman of the MSMS Committee on Publications and the MSMS Advisory Committee on Communications and Professional Relations. He is a member of the Board of Directors, Physician Service Group, Inc., and the Wayne County Medical Society Board of Trustees. Doctor Domzalski received his degree from the University of Michigan Medical School.*

Lionel E. Dorfman, MD, *a Battle Creek urologist, has held a variety of posts with MSMS and other professional organizations, including member of the MDPAC Board of Directors, member of the Liason Committee with MPRO and delegate to the MSMS House. Doctor Dorfman is a past president of the Calhoun County Medical Society. He earned his medical degree from the University of Toronto.*



Peter A. Duhamel, MD, *a Rochester general surgeon, is past chairman of MDPAC, member of the MSMS Hospital Medical Staff Section Governing Council, an alternate delegate to the AMA, and past president of Oakland County Medical Society. Doctor Duhamel is vice chairman of the AMA Hospital Medical Staff Section and is a graduate of St. Louis University.*

James L. Fenton, MD, *a Bay City radiologist, is past president of the Michigan Board of Medicine and the Bay County Medical Society. A graduate of the Wayne State University School of Medicine, Doctor Fenton is a member of the MSMS Committee on Publications, the MSMS Committee on Bioethics and the MSMS Committee on Medical Licensure and Discipline.*

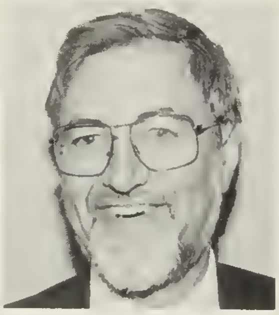
Continued on next page

David H. Gilbert, MD, *a Calumet surgeon, is a member of the MSMS Task Force on Rural Health Care. He is a graduate of the University of Michigan Medical School.*

John W. Hall, MD, *a Petoskey urologist, is a member of the MSMS Committee on Publications, and heads the Board's Committee on Scientific and Educational Affairs. He is a member of MPMLC and serves as an alternate delegate to the AMA. He is a graduate of the University of Michigan Medical School.*

Carl F. Hammerstrom, MD, *a Marquette pulmonary and critical care specialist, is former chairman of the MSMS Committee on CME Programming. He is a trustee of the Michigan Society of Internal Medicine and of the American Lung Association of Michigan. He earned his medical degree from Johns Hopkins University.*

Thomas D. Harris, MD, *a Jackson dermatologist, has been a member and past president of the Public Service Committee and is a former president of the Jackson County Medical Society. Doctor Harris has served as chairman of DRACP-ACCESS.*



David M. C. Hislop, MD, *a Port Huron obstetrician and gynecologist, has been a member of the MSMS Ways & Means Committee for the past four years. A graduate of the University of Glasgow in Scotland, Doctor Hislop has served as an alternate delegate and delegate to the MSMS House for 16 years. He is a member of the MSMS Committee on Maternal and Perinatal Health.*

Richard P. Horsch, MD, *a Farmington anesthesiologist, is president of the Michigan Society of Anesthesiologists; past president, Wayne County Medical Society; delegate to the MSMS House; and is associate editor of the* Detroit Medical News. *He is a graduate of the Wayne State University School of Medicine.*

John H. McLaughlin, MD, *a Birmingham general surgeon, is a fellow of the American College of Surgeons and is a past president of the Michigan Chapter, American College of Surgeons. He has held a variety of MSMS posts and currently serves as member-at-large of the MSMS Hospital Medical Staff Section Governing Council. Doctor McLaughlin is a graduate of the University of Michigan Medical School.*

David J. Millard, MD, *a Paw Paw family physician, has served as a delegate to the MSMS House for more than 25 years. He is former chairman of the MSMS Committee on Constitution and Bylaws and past president of the Van Buren County Medical Society. A graduate of the University of Michigan Medical School, he is chief medical examiner for Van Buren County. He is a member of the MSMS Committee on CME Accreditation, the MSMS Committee on CME Programming and the Planning Committee for the MSMS Annual Scientific Meeting.*

Frederick V. Minkow, MD, *a Bloomfield Hills orthopedic surgeon, is a graduate of the University of Michigan Medical School. He is former chairman of the MSMS Committee on State Legislation and Regulations, past president of the Oakland County Medical Society, and former chairman of the Oakland County Medical Society's legislative committee. He currently serves on the Board of Directors of MSMS and MPMLC.*

Earl G. Moehn, MD, *a Mount Clemens general surgeon, is past president of the Macomb County Medical Society and is a Fellow of the American College of Surgeons. He has served as chairman of the MSMS Committee on Constitution and Bylaws. Doctor Moehn is a graduate of the Wayne State University School of Medicine.*

Fred E. Patterson, MD, *a Jackson radiologist, is director of radiology at Foote Memorial Hospital. He is former chairman of MSMS Public Affairs Leadership Conference and is a past president of the Washtenaw County Medical Society. He received his degree from the University of Iowa College of Medicine.*

Krishna K. Sawhney, MD, *a Detroit general vascular surgeon, is chairman of the MSMS Hospital Medical Staff Section; chairman of MDPAC; president Wayne County Medical Society; associate editor of* Detroit Medical News *and delegate to the AMA Hospital Medical Staff Section. He graduated from Rajendra Medical College in Ranchi, India.*

Marguerite Shearer, MD, *an Ann Arbor family physician, is medical director of the Huron Valley Physicians Association. A graduate of the University of Michigan Medical School, she is director of Michigan Academy of Family Physicians. A member of the MSMS Committee on Publications, Doctor Shearer also heads the MSMS Board's Legislative Policy committee. She is a member of the MDPAC Board and serves as an alternate delegate to the AMA.*

Willard S. Stawski, MD, *a Grand Rapids surgeon, is an alternate delegate to the AMA; member of the Board of Directors, Physicians Review Organization of Michigan; and a member of the MSMS Liaison Committee with BCBSM. A graduate of the University of Michigan Medical School, Doctor Stawski is a former president and secretary/treasurer of the Kent County Medical Society.*

Thomas E. Stone, MD, *a Muskegon urologist, is a former delegate to the MSMS House as well as past president of the Muskegon County Medical Society. He also is past president of MDPAC and current member, Board of Trustees, Hackley Hospital, Muskegon. A graduate of the University of Michigan Medical School, Doctor Stone currently serves as chairman of the MSMS Task Force on Professional Liability.*

Charles C. Vincent, MD, *a Detroit obstetrician/gynecologist, is associate professor, obstetrics/gynecology, Wayne State University School of Medicine, and cheif of gynecology, Hutzel/Detroit Receiving hospitals. He is past president of the Detroit Medical Society, the Wayne County Medical Society and the Michigan Board of Medicine. A graduate of the Wayne State University School of Medicine, Doctor Vincent is a member of the Michigan Delegation to the AMA.*

B. David Wilson, MD, *a Kalamazoo allergist, is a member of the board of directors, MDPAC. He is an alternate delegate to the AMA and is past president of the Kalamazoo Academy of Medicine and Michigan Allergy Association. A graduate of the Wayne State University School of Medicine, Doctor Wilson currently heads the MSMS Board's Finance Committee.*

Special guests invited to every MSMS Board of Directors meeting are: **AppaRao Mukkamala, MD,** *representing the MSMS Section for International Medical Graduates;* **Mark Sawka, MD,** *representing the MSMS Resident Physician Section;* **Roger Diegel,** *representing the MSMS Medical Students Section;* **Krishna K. Sawhney, MD,** *representing the MSMS Hospital Medical Staff Section;* **Lois Duhamel,** *representing the MSMS Auxiliary; and* **Tama D. Abel, MD,** *representing the MSMS Young Physicians Section.*

EXECUTIVE DIRECTOR

William E. Madigan *has been with MSMS for 16 years, the last four as the executive director. Mr. Madigan attended Michigan State University, holds a bachelor's degree from Ferris State College and is currently working on a master's degree in health administration from the University of Michigan.*

ASSISTANT DIRECTOR

Kevin A. Kelly *has been with MSMS for 12 years, the last four years as assistant director. Mr. Kelly has a bachelor's degree from Michigan State University and is currently working on a master's degree from Western Michigan University.*

LEGAL COUNSEL

Richard D. Weber *received a JD with distinction from Wayne State University Law School in 1963. He is a member of the American, Michigan, Oakland and Detroit Bar Associations. He is a partner in the Detroit law firm of Kerr, Russell and Weber. Mr. Weber has served as legal counsel for MSMS for six years. He is a member of the American Society of Medical Association Counsel.*

MSMS Committees and Chairmen

Committee on Aging
James G. O'Brien, MD

Committee on MSMS Archives
Frederick W. Bryant, MD

Task Force on AIDS Education
Robert D. Allaben, MD

Liaison Committee With Michigan Medical Arbitration System
Gerald H. Mandell, MD

Committee on Awards
Billy Ben Baumann, MD

Committee on Bioethics
Howard A. Brody, MD

Liaison Committee with Blue Cross Blue Shield of Michigan
Gary D. Maynard, MD

Committee on Communications and Professional Relations
Henry M. Domzalski, MD

Committee on Constitution and Bylaws
Steven E. Newman, MD

Committee on CME Accreditation
Donald J. Aiken, MD

Committee on CME Programming
David R. Rovner, MD

Advisory Committee on Health Care Policy
Fred E. Patterson, MD

Steering Committee on Program to Assist Impaired Physicians
Robert Niccolini, MD

Committee on Maternal and Perinatal Health
Robert P. Lorenz, MD

Advisory Committee to Section on Medical Economics
Gilbert B. Bluhm, MD

Task Force on Rural Health Care
Frederick V. Bryant, MD

Liaison Committee with Michigan Peer Review Organization (MPRO)
Robert C. Packer, MD

Advisory Committee on Office Automation
Jack L. Barry, MD

Planning Committee for Michigan Conference on Maternal and Perinatal Health
Federico G. Mariona, MD
David Sciamanna, DO

Planning Committee for MSMS Annual Scientific Meeting
Conrad E. Nagle, MD

Committee on MSMS Policy
Robert E. Paxton, MD

Hagadorn, Inc.
Leland E. Holly, II, MD

Task Force on Professional Liability
Thomas E. Stone, MD

Medicaid Liaison Committee
Cecil R. Jonas, MD

Committee on Medical Licensure and Discipline
Donald H. Kuiper, MD

Committee on Membership and Recruitment
Dorothy Kahkonen, MD

Liaison Committee with Michigan Department of Public Health
Douglas E. Mack, MD

Michigan Doctors Political Action Committee Board of Directors
Mitchell A. Rinek, MD

Committee on Federal Legislation
Thomas E. Stone, MD

Governing Council, MSMS Section for International Medical Graduates
Appa Rao Mukkamala, MD

Governing Council, Hospital Medical Staff Section
Krishna K. Sawhney, MD

Governing Council, Medical Student Section
Roger Diegel

Governing Council, Resident Physician Section
Mark Sawka, MD

Governing Council, Young Physicians Section
Tama D. Abel, MD

Committee on Publications
Henry M. Domzalski, MD

Committee on Sports Medicine
Perry W. Greene, Jr., MD

Committee on State Legislation and Regulations
Mitchell A. Rinek, MD

Task Force on Health Care for the Uninsured
Marguerite Shearer, MD

Committee on Ways and Means
Robert C. Prophater, MD

Committee on Concerns of Women Physicians
Martha L. Gray, MD

Task Force on Environment and Health
Susan H. Adelman, MD

Focus Group on Chemical Dependency
Susan H. Adelman, MD

MSMS Year in Review

Excerpts from the 1991 Report of the MSMS Board of Directors

PATIENT ADVOCACY

MSMS fought for Medicaid patients by initiating the "43 Cents on a Dollar — The False Promise of Medicaid" campaign. After state budget cuts were announced, MSMS attempted to keep the physician portion of the Medicaid budget from being cut further. MSMS is continuing to oppose the budget cuts through letters, direct physician contact with individual legislators, and meetings between MSMS representatives and key members of the appropriations committee.

In coalition with the Michigan Association of Osteopathic Physicians and Surgeons (MAOP&S), the Michigan Hospital Association (MHA) and the State Bar of Michigan, MSMS developed a Designation of Patient Advocate Form that allows patients to appoint someone else to make care, custody and treatment decisions for them if they become incapacitated. This was in the wake of new legislation allowing the creation of a durable power of attorney for health care. MSMS will undertake a public education campaign to get this information and designation forms to the people of Michigan, and will serve as a vehicle to distribute the forms.

The MSMS Board of Directors supported the AMA 16-point Health Access America plan and is seeking solutions for the uninsured through the MSMS Task Force on Health Care for the Uninsured.

CARING CAMPAIGN

MSMS developed and distributed public service announcments on a variety of environmental issues to television stations statewide.

The contributions of MSMS physicians to their local communities were highlighted in "Doctor's Day" materials to statewide media. The publicity campaign included a press conference with Governor John Engler proclaiming March 30 as Doctors' Day in Michigan.

Scores of MSMS physicians underwent media training to help them convey MSMS' message to the public via the media in their areas. They became a part of the Physician Communication Network which is designed to respond to negative press and promote positive press about physicians' activities.

HEALTH CARE COST CONTAINMENT

Oakland County became the first county to set up a community roundtable discussion of health care centered on the cost containment issue. This extremely successful event drew much public and media attention. A panel of six people from various interest groups discussed their points of view, including the AMA's Health Access America 16-point plan. Other counties will be encouraged to establish similar events in their areas.

CHEMICAL DEPENDENCY

Under the leadership of Susan Hershberg Adelman, MD, MSMS president, a special Focus Group on Chemical Dependency was formed. Last fall the Focus Group participated in the Medicine-Education-Legal-Law Enforcement (MELL) Team Against Drugs Project initiated in cooperation with then Supreme Court Justice Dennis Archer. The giant effort involved putting together 156 health professional, lawyer, and law enforcement teams to present anti-drug programs simultaneously in every elementary school in Detroit. The MSMS program will be expanded to other school districts in the state this year.

The Focus Group has begun development of a physician's handbook for recognizing and treating chemical dependency. Other projects being pursued by the Focus Group include (1) publication of an annotated directory of treatment facilities, (2) inclusion of more courses on chemical dependency in medical school curricula and (3) institution of more hospital program for the joint treatment of the addicted mother and her infant.

MEDICAL LIABILITY REFORM

In a coalition with MAOP&S and MHA, MSMS worked with Senator Dan DeGrow, and Senator John J. H. Schwartz, on the bills they introduced to establish and alternative system for settling professional liability claims and for instituting needed tort reforms. The coalition will work together for passage of these bills during this session of the Legislature. The future of this legislation looks positive because of the election of John Engler as Governor, Robben Fleming's data showing Michigan's high liability insurance premium costs and because of the concern generated by the multi-million dollar jury award against Hutzel Hospital.

The coalition has begun soliciting other groups including business associations, professional associations, other health care groups, and county governments to join in a petition to the Michigan Supreme Court asking for reinstitution of the sliding fee scale for attorneys.

MSMS also is seeking countersuit legislation, supports the bills to improve the licensure and discipline system, and supports the establishment of a state legal expense fund.

REPRESENTING PHYSICIANS IN THE LEGISLATURE

MSMS was extremely active in the development of the bills to improve the physician licensure and discipline system and the bills concerning medical liability. MSMS also fought bills that would expand the scope of practice of allied health care workers. MSMS successfully defeated a bill to require physicians to accept assignment on all Medicare claims. The Society continues to provide input into the assisted suicide bill; fight health care budget cuts; and support Senator Schwarz's bill to expand the "Good Samaritan" law.

LICENSURE AND DISCIPLINE

MSMS worked closely with Representative David Gubow, and Representative Rick Bandstra on a bi-partisan package of bills to improve the physician licensure and discipline system. The bills have passed the House and are now in the Senate Health Policy Committee. The bills include a nine-month limit on actions and additional funding for more investigative staff.

THIRD PARTY PAYORS

MSMS physicians and staff spent countless hours in an attempt to favorably influence the new Blue Cross Blue Shield of Michigan physician contract. Without this input, the contract would have been much more unfavorable. A new committee of BCBSM and physicians was established in the wake of the new contract to work on problems that come up as a result of the contract. In this committee, the BCBSM Physician Advisory Committee, MSMS and MAOP&S were able to convince the Blues to rewrite the definition of "medical necessity." The new language states "Physicians determine medical necessity." The findings of a 40 percent payment disparity between Michigan Blues and surrounding states' Blues are under discussion in this committee. MSMS has convinced the Blues to add more than 20 service representatives to improve billing problems.

Dozens of issues continue to be discussed with the Blues, with potentially favorable outcomes for many of them. MSMS appointed a staff person as the BCBSM ombudsman who can cut through busy signals and red tape when physicians have particularly difficult problems with the Blues.

In conjunction with the AMA, MSMS vigorously fought "hassle" legislation in the U. S. congress.

RISK MANAGEMENT

With the support of the Michigan Physicians Mutual Liability Company (MPMLC), MSMS has developed the MSMS Department of Risk Management to increase physician involvement in the planning and implementation of risk management activities. Since its inception, numerous risk management programs have been conducted in locations throughout the state. A priority of the Department is to inventory practice parameter development by specialty societies and coordinate involvement of MSMS members in practice parameter related projects.

MEDIA/PUBLIC RELATIONS

Calls from the media for MSMS positions and statements on a wide variety of health related topics quadrupled last year as MSMS became recognized by the media as a reliable, influential source. Much media attention focused on the right to die issue following Doctor Kevorkian's assisted suicide in Oakland County.

HOSPITAL MEDICAL STAFFS

The Medical Society has taken an active role in aiding hospital medical staff officers and members in matters pertaining to bylaws, credentialing and resolving challenges among the medical staffs, board of directors, and administration.

Hospital medical staffs in Michigan were assisted by the Physician Issues Presentation III program. This program makes MSMS officers available as speakers to medical staff meetings on a variety of subjects pertinent to the practice of medicine.

MSMS Task Force on Rural Health was instrumental in the development and passage of legislation to improve the plight of the small community hospital. The Task Force also assisted Michigan State University in the establishment of a Center for Rural Health to address continuing problems.

AIDS

MSMS renegotiated its contract with the Michigan Department of Public Health to continue the very successful AIDS Provider Education Program. This program has provided more than 30,000 people, primarily physicians and allied health workers, with the latest information on the prevention, diagnosis and treatment of AIDS.

MSMS was successful in stopping passage of HB 5701, Mandatory AIDS Education. This legislation would have added education on AIDS and HIV infection to the requirements for licensure or registratrion of health care professionals.

PHYSICIAN RECOVERY NETWORK

The Physician Recovery Network has grown to the point where it is necessary to computerize its records to track those in the program and to analyze data to recognize similar factors leading to chemical dependency and the best reatment regimen outcomes. Funding continued to be a problem last year and will be again this year despite generous grants from MPMLC and the Physicians Insurance Company of Michigan. Grants are being written to seek foundation funding of this important program.

NON-DUES INCOME

The Board approved, primarily for tax benefits, the creation of a new holding company for PSG and PROM, the two wholly-owned for-profit subsidiaries of MSMS. MSMS is the sole stockholder of the new holding company.

The Board also approved the concept of the establishment of a printing company to print MSMS, county society and outside materials. The feasibility of the printing company continues to be explored.

NATIONAL PRACTITIONER DATA BANK

The National Practitioner Data Bank officially went into effect on September 1, 1990. The provisions of the Data Bank require that the following four types of action be reported to the Bank, via the Michigan Department of Licensing and Regulation: medical malpractice payments, licensure actions taken by the Board of Medicine, clinical privilege adverse actions by hospitals or other health entities, and medical society adverse membership actions.

The MSMS Board of Directors remains in close consultation with MSMS legal counsel to ensure that the Society is in compliance with the NPDB reporting requirements, particularly as they pertain to the Judicial Commission, the Physicians Recovery Network and the Hospital Medical Staff Section. In addition, two staff members have been designated to work directly with the Department of Licensing and Discipline and be responsible for receiving and reporting of information in accordance with NPDB regulations.

STRATEGIC PLANNING

The 1990 House of Delegates passed a resolution requesting the Board to appoint a contingency planning committee. At the July 14, 1990, meeting of the Board, Doctor Barry, chairman of the Board, appointed a Strategic Planning Committee consisting of Susan H. Adelman, MD; Robert D. Allaben, MD; Billy Ben Baumann, MD; Robert W. Black, MD; Robert D. Burton, MD; John W. Hall, MD; Gary D. Maynard, MD; W. Peter McCabe, MD; Robert E. Paxton, MD; Marguerite Shearer, MD; B. David Wilson, MD; and Doctor Barry.

The Strategic Planning Committee has met five times. The first two meetings were devoted to obtaining background information to determine MSMS' current position and future possbilities. Subsequent meetings were with AMA planner, Bruce Balfe. A summary of these meetings will be presented to the 1991 MSMS House of Delegates for review and comment.

FINANCES

The 1990 House of Delegates authorized a $90 dues increase. Your Board has made it a top priority to reduce expenditures wherever possible and at its October 31, 1990, meeting approved an extremely frugal 1991 Operating Budget.

The Finance Committee and the Board, as far as possible, met the three-year financial plans approved by the House of Delegates in 1984 and 1987. A comparison of projected versus audited Operating Fund year-end surpluses (deficits) for both the FY 1985-FY 1987 and the FY 1988-FY 1990 plans follows:

The main reason for the larger than projected deficit in FY 1990 was the payment of federal income taxes for both 1989 and 1990 because MSMS can no longer offset the loss from the publication of *Michigan Medicine* against other non-dues income. In addition, dues income was lower than projected.

For FY 1991, the Board is operating under an austere expense budget of $5,111,300. This is $132,475 lower than the $5,243,775 expense budget contained in the first year of the FY 1991-FY 1993 financial plan approved by the House of Delegates last year.

Financially speaking we had some good news this year. The chiropractic antitrust case was settled without cost to MSMS and we received a favorable ruling from the IRS in the issue of commingling PAC funds with MSMS funds.

POLICY ACTIONS OF THE BOARD

Since the last meeting of the House of Delegates the Board has considered some matters where MSMS policy was not clear or did not exist. In these instances, the Board has taken action which constitute statements of MSMS policy. These statements are given below for the information of the Delegates. They will be incorporated in the MSMS Policy Manual along with the policy actions of the 1991 House of Delegates.

1.Statement on Physician-Assisted Suicide

"The recent use by a Michigan physician of a 'suicide device' to end the life of a patient with Alzheimer's disease attests to concerns deeply felt by many patients — that they will suffer and lose control of their lives as they face chronic and terminal illness. These concerns are reflected in public opinion polls, which consistently show that 50 to 60 percent of Americans favor active euthanasia or mercy killing as an option.

"Hypothetically, the decisions that might be made in terminal illness, or severe chronic illness with severely reduced quality of life, are illustrated by the following spectrum:

1. Discontinuing life support measures;
2. Providing patients with sufficient analgesia to control pain, even though this may depress vital functions;
3. Providing patients with enough analgesic or sedative medication to constitute a lethal dose if taken all at once, with the knowledge that the patient may elect to commit suicide by this means;
4. Directly administering a lethal quantity of medication.

"Many physicians would allow #1 and #2 while steadfastly opposing #3 and #4, arguing that the physician must be dedicated to healing and never to causing the death of the patient. Others would argue that the complexities of actual clinical cases make it extremely difficult to draw such a sharp dividing line which can be defended with cogent ethical reasoning. For many physicians who accept #1 and #2 while opposing #4, assisted suicide (#3) represents a moral gray zone.

"The 'suicide device' used in Michigan appears to some in its clinical and ethical implications to be more akin to active euthanasia (#4) than to assisted suicide (#3). While use of the machine may arguably reduce the physician's legal responsibility for the patient's death, the ethical responsibility appears to be as great as if the physician had chosen directly to administer the lethal injection.

"It is not enough, however, to righteously condemn the use of this 'suicide device,' unless we forthrightly address the underlying concern of humane and compassionate terminal care for all patients. While these issues are societal, rather than purely medical, physicians nevertheless have a special obligation to make clear our basic professional values.

"We encourage all Michigan physicians to enhance the quality of care of these patients in the following ways:

1. Become acquainted with the most modern methods of symptom control and emotional support for palliative terminal care, or learn which local individuals and groups can provide such services for their patients.
2. Assure chronically or terminally ill patients that their consent is required before any medical interventions will be used, and invite them to discuss their wishes and values regarding such care.
3. Become familiar with existing modes of advance directives (durable powers of attorney for health care; 'living wills'), ask all patients whether they have executed or wish to execute such documents, and assist them as appropriate in doing so. The MSMS Committee on Bioethics is currently working to compile examples of advance directive documents which appear suitable for use in Michigan."

2. Revision of MSMS Policy on Endorsement of Practice Recommendations.

"a. The development of guidelines, recommendations or protocols which prescribe standards of medical practice is the responsibility of physicians.

"b. MSMS should assume a proactive role in the dissemination of practice recommendations developed by the American Medical Association, its component societies and recognized specialty societies; in the identification of areas where practice recommendations are needed; and in the development of practice recommendations in those areas.

"c. MSMS does not endorse guidelines, recommendations or protocols which prescribe, or may be interpreted as prescribing, standards of medical practice, unless they are endorsed by the American Medical Association, its component societies, or recognized specialty societies.

"d. If a governmental agency perceives a need to develop practice recommendations in response to a pressing public health problem, MSMS will evaluate the need for recommendations and cooperate in the effort through the following measures:

1) If no recommendations are available from the American Medical Association, its component societies and recognized specialty societies, MSMS may offer to convene an expert committee.

2) MSMS, when appropriate, may assist in efforts to disseminate the recommendations to physicians and to the public.

"e. MSMS will continue to promote physician involvement in state government committees where physician expertise is needed to assist a state government agency in carrying out statutory responsibilities with respect to the protection of the public health." ■

BALANCE SHEET

Michigan State Medical Society

November 30, 1990

ASSETS	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
CURRENT ASSETS:						
Cash and cash equivalents	$1,331,051	$ 200,699	$ 250,147	$ 13,795	$ 806	$1,796,498
Short-term investments		652,954	153,565	96,877		903,396
Accounts receivable:						
Group Insurance Trust			4,812			4,812
Michigan Doctors Political Action Committee	4,727					4,727
Advertisers and other	250,147		31,375			281,522
Due from (to) other funds	92,976	(15,545)	(77,431)			
Due from unconsolidated subsidiary	7,089					7,089
Accrued interest receivable	4,417	3,023				7,440
Prepaid expenses	14,963	429	2,547			17,939
TOTAL CURRENT ASSETS	1,705,370	841,560	365,015	110,672	806	3,023,423
INTANGIBLE PENSION ASSET	35,240					35,240
LONG-TERM INVESTMENTS		100,624		21,559	890,084	1,012,267
INVESTMENT IN JOINT VENTURE		756,477				756,477
RESTRICTED CASH	1,200					1,200
PROPERTY AND EQUIPMENT	2,185,122	398,389				2,583,511
TOTAL ASSETS	$3,926,932	$2,097,050	$ 365,015	$132,231	$890,890	$7,412,118

LIABILITIES AND FUND BALANCES	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
CURRENT LIABILITIES:						
Accounts payable:						
American Medical Association	$ 279,980					$ 279,980
County medical societies	175,316					175,316
Michigan Doctors Political Action Committee	15,503					15,503
Trade	159,038		$ 23,091			182,129
Accrued liabilities	188,928		3,036			191,964
Accrued reimbursement on AIDS contract	28,000					28,000
Prepaid dues	453,687					453,687
Deferred revenue			33,333			33,333
Accrued income taxes	24,000					24,000
Accrued interest due to (from) other funds	(38,743)		38,743			
Current portion of notes due to (from) other funds	(30,000)		30,000			
Current portion of long-term debt	34,284					34,284
TOTAL CURRENT LIABILITIES	1,289,993		128,203			1,418,196
LONG-TERM DEBT, less current portion:						
Due to (from) other funds	(360,000)		360,000			
Mortgage payable	1,356,213					1,356,213
FUND BALANCES	1,640,726	$2,097,050	(123,188)	$132,231	$890,890	4,637,709
TOTAL LIABILITIES AND FUND BALANCES	$3,926,932	$2,097,050	$ 365,015	$132,231	$890,890	$7,412,118

STATEMENT OF REVENUES AND EXPENSES

Michigan State Medical Society

November 30, 1990

ASSETS	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Eliminations	Total
REVENUES:							
Dues – membership	$2,933,516						$2,933,516
Dividends and interest	251,211	$ 43,544	$ 21,617	$ 6,764	$95,147	$144,373	273,910
Michigan Medicine Magazine:							
Advertising	141,553						141,553
Subscriptions	16,637						16,637
Administration and physician education	342,143						342,143
Government relations	106,689						106,689
Finance and operations	118,093						118,093
Dues collection fees	24,392						24,392
Gain on sale of investments		118,906	144,944	6,946			270,796
Automobile rental income		81,480					81,480
Rental income	427,136					122,589	304,547
PSG services to medical practitioners			1,180,370				1,180,370
PROM peer review services			301,871				301,871
Other	369,111					29,500	339,611
TOTAL REVENUES	4,730,481	243,930	1,648,802	13,710	95,147	296,462	6,435,608
EXPENSES:							
Office of the directors	1,097,033		18,000				1,115,033
Administration and physician education	574,188	13,939	9,100	5,000			602,227
Communication and professional relations	683,038						683,038
Medical economics	193,676						193,676
Government relations and membership development	671,936						671,936
Hospital physician relations	157,436						157,436
Finance, member services, and operations	1,710,337	66,833					1,777,170
PSG services to medcal practitioners			1,074,200			107,076	967,124
PROM peer review services			302,123			84,386	217,737
Interfund dividends			105,000			105,000	
TOTAL EXPENSES	5,087,644	80,772	1,508,423	5,000		296,462	6,385,377
REVENUES OVER (UNDER) EXPENSES BEFORE TAXES ON INCOME OF CONSOLIDATED SUBSIDIARY, EXTRAORDINARY CREDIT AND NET LOSS OF JOINT VENTURE	(357,163)	163,158	140,379	8,710	95,147		50,231
TAXES ON INCOME OF CONSOLIDATED SUBSIDIARY			42,000				42,000
REVENUES OVER (UNDER) EXPENSES BEFORE EXTRAORDINARY CREDIT AND NET LOSS OF JOINT VENTURE	(357,163)	163,158	98,379	8,710	95,147		8,231
EXTRAORDINARY CREDIT – Tax credit from utilization of operating loss carryforward			7,000				7,000
REVENUES OVER (UNDER) EXPENSES BEFORE NET LOSS OF JOINT VENTURE	(357,163)	163,158	105,379	8,710	95,147		15,231
NET LOSS OF JOINT VENTURE		(24,775)					(24,775)
REVENUES OVER (UNDER) EXPENSES	$ (357,163)	$138,383	$ 105,379	$ 8,710	$95,147	None	$ (9,544)

AUDITOR'S REPORT

We have audited the accompanying consolidated balance sheet of Michigan State Medical Society and subsidiaries as of November 30, 1990, and the related consolidated statements of revenues and expenses, changes in fund balances, and cash flows for the year then ended. These financial statements are the responsibility of the Society's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statments. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Michigan State Medical Society and subsidiaries as of November 30, 1990, and the results of their operations and their cash flows for the year then ended in conformity with generally accepted accounting principles.

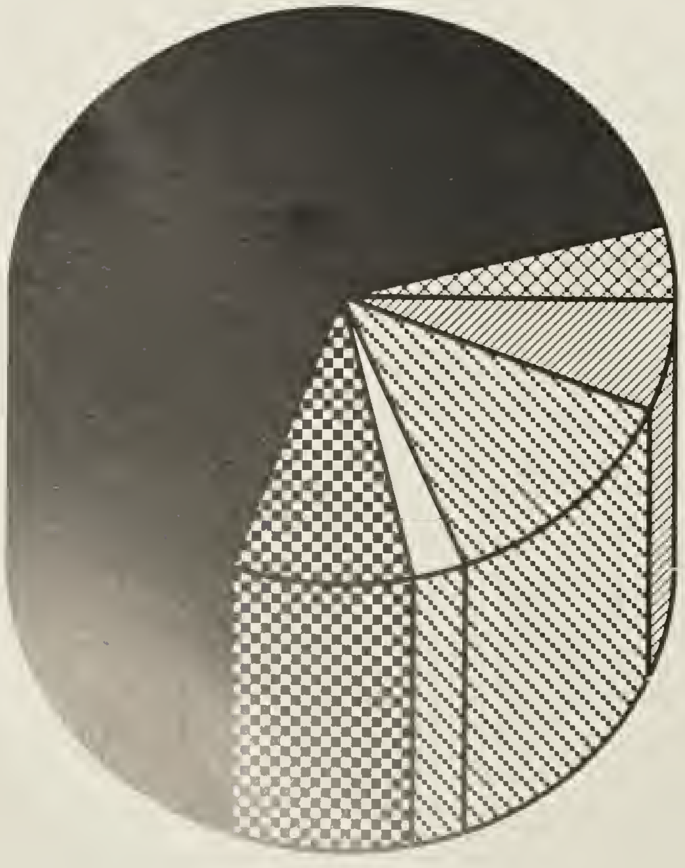
Deloitte & Touche

Certified Public Accountants
January, 28, 1991

*Notes to financial statement are not included.

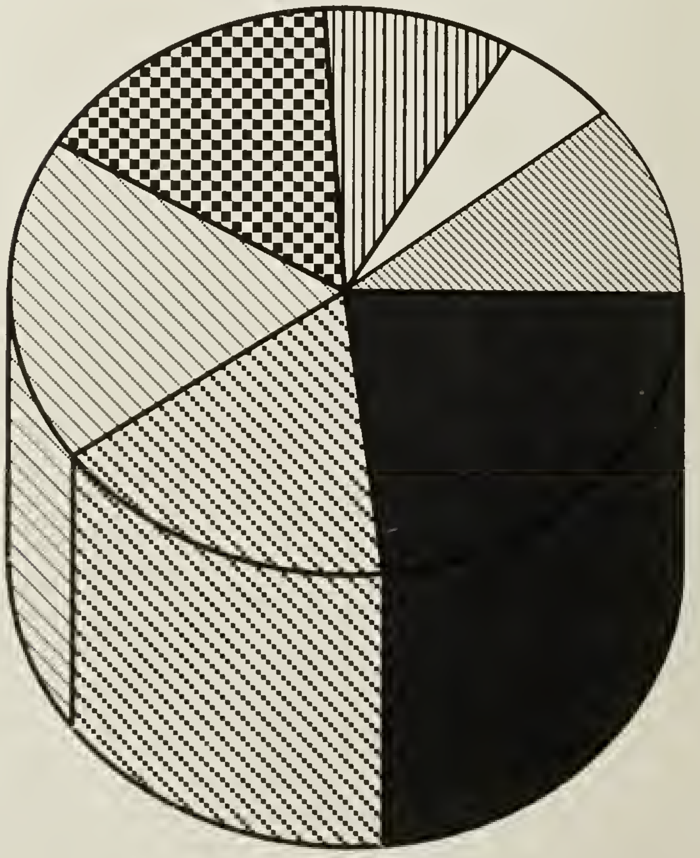
1990 OPERATING INCOME

- ▨ Administrative Services 6.21%
- ▧ Conferences 12.67%
- ☐ Grants 2.60%
- ▦ Investment Income 8.83%
- ■ Membership Dues 65.43%
- ▩ Publications 4.26%



1990 OPERATING EXPENSES

- ■ Operating and Buildings 23.11%
- ▩ Administration 16.81%
- ▧ Physician Education 18.70%
- ▦ Communications and Public Relations 15.37%
- ▥ Government Relations 9.2%
- ☐ Finance 5.76%
- ▨ Hospital and Third Party Payor Relations 11.05%



WHOM TO CALL AT MSMS HEADQUARTERS

EXECUTIVE DIRECTOR: WILLIAM E. MADIGAN
ASSISTANT DIRECTOR: KEVIN A. KELLY
(517) 337-1351

The individuals listed at right are a very integral part of the Michigan State Medical Society – they are the staff. The 62 members of the staff provide a wealth of information and assistance every day to MSMS members who have questions and want answers.

Here are just a few of the questions MSMS has received and answered: "Medicare has not sent a payment in three months and I have provided over $60,000 worth of treatment. Who can I talk to at BCBSM about this problem?" "I neglected to renew my license and I am scheduled for surgery tomorrow. I cannot reach the Department of Licensing and Regulation. Can you help me?" Staff was able to provide assistance to these physicians and stands ready to assist the membership everyday.

Do not forget that the MSMS staff members listed at right can help you through a bureaucratic maze, give you the most complete information about the current health care delivery system, or simply provide you with directions to the MSMS building. If you have questions, we encourage you to pick up the phone and call us.

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Betty McNerney
AIDS Provider Education Project	Tracy Baker
AMA Delegation	Judy Marr
Annual Scientific Meeting Program	Lori Randall
Arbitration	Dan Farhat, Sandra Bitonti
Auto Lease Plan	Richard Campau
Blue Cross Blue Shield/Third Party Payors	Mary Anne Ford
Board of Medicine	Dan Farhat, Tom Wolff
Continuing Medical Education	
Accreditation	Vada Davis
Category I Calendar (in *Michigan Medicine*)	Sarah Cressman
MSMS-Sponsored Conferences	Lori Randall
Dues Billing & Payments	Peg Berry
Federal Legislation	Kevin Kelly
Financial Operations	Richard Campau
Graduate Medical Education	Sherry Fent
Group Health Insurance Plan	Barb Zimmerman, Valerie Barker
Health Data Research	Julie Lester
Health Education Foundation	Richard Campau, Dawn Reha
HMOs/PPOs	Mary Anne Ford
Hospital Medical Staff Relations	Tom Plasman
Judicial Commission	Katie Brewbaker
Legislation	Dan Farhat
Maternal Health Conference	Sarah Cressman
Media Relations	David Fox
Medicaid	Tom Wolff
Medical Assistants	Caroline Kimmel
Medical Ethics	Katie Brewbaker
Medicare	Rose Heald
Medigram	Betty McNerney, Claudia Skutar
Member Benefits (including insurance programs)	Richard Campau
Membership Records	Peg Berry
Membership Recruitment	Deborah Zannoth
Michigan Allergy Society	Viola Heins
Michigan Association of Medical Education	Viola Heins
Michigan Chapter, American College of Obstetricians & Gynecologists	Viola Heins
Michigan Dermatological Society	Dawn Reha
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medical Group Managers Association	Caroline Kimmel
Michigan Medicine (MSMS Journal)	Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
Michigan Society of Internal Medicine	Caroline Kimmel
Michigan Society of General Surgeons	Caroline Kimmel
Michigan Society of Pathologists	Viola Heins
Michigan Society of Respiratory Care	Caroline Kimmel
MPRO Ombudsman	Tom Plasman
MSMS Auxiliary	Dawn Reha
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	Richard Campau, Donna Farougi
MSMS Meeting Facilities	Stacy Kohmetscher
MSMS Travel Programs	Donna Farougi
Physicians Communication Network	Katie Brewbaker
Physicians Recovery Network	Katie Brewbaker
Physician Review Organization of Michigan, Inc. (PROM)	John Richards, Jim Tarrant, Barbara Banks, RN
Physician Legislative Network	Sandra Bitonti
Physician Service Group, Inc.	John Richards
Practice Management	John Richards, Dawn Reha
Seminars	Roberta Lott
Professional Liability	Tom Wolff
Public Health Liaison	Tom Wolff, Sandra Bitonti
Public Relations	Judy Marr
Reimbursement Ombudsman	Rose B. Heald
Risk Management	Julia Smith
Specialty Societies	Donna Farougi

MICHIGAN STATE
18 66
MEDICAL SOCIETY

Psychiatric and Substance Abuse Peer Review has yet to find acceptance among Michigan physicians

By Ralph D. Ward

The concept of peer review of medical and surgical services has gained respect over the years as an objective, realistic way to evaluate the need for and quality of care. Indeed, with the enormous cost pressure faced by all members of the health care profession, peer review's emphasis on efficiency has made it invaluable. But what about effective peer review of less concrete service, like psychiatric and substance abuse?

The costs of third party payers and employers of these services have soared even faster than the general health care bill in recent years, reaching $200 billion nationally in 1989. The concept of effective, cost-based review of psychiatric and substance abuse services was inevitable given these cost pressures, but has yet to find full acceptance among Michigan physicians. Barbara Banks, RN, Chief, review services, Physicians Review Organization of Michigan (PROM), is enthusiastic about the acceptance PROM has found for its peer review services, but understands the concerns of some physicians. "How is the review for psychiatric or behavioral medicine the same or different for medical or surgical care? You can tell if a gall bladder needs to be removed, but how do you tell how long a psychiatric patient needs to be in the hospital?"

Although the acceptance of peer review in these areas seems assured, opinions vary depending on one's position in the health care circle, from physicians, to third party payers, to employers. PROM's services, for instance, "are fairly well accepted by those in a stated field, though there is not yet full agreement on analysis or methods," according to Donald C. Smith, MD, a member of the PROM board and a former director of the Michigan Department of Mental Health. "PROM is able to bring a critical and constructive approach to psychiatric and abuse services because it's patient care oriented, rather than looking narrowly at expenditures." PROM also treats such services as health care services rather than social programs, according to Smith, an attitude that encourages objective, results-oriented reviews.

Private review soaring

The major private psychiatric and substance abuse review services have enjoyed a boom in recent years as payers seek to manage the costs of services. Foremost among review organizations operating in Michigan has been Preferred Health Care (PHC). First offering service in 1983, PHC pioneered telephone, concurrent utilization care reviews, as opposed to the usual retrospective reviews. Their Psychiatric Case Review program encourages collegial, clinically-focused review at the time of treatment.

PHC's review programs have grown to be the nation's largest, covering nearly 3.5 million people nationwide. Their PsyCare program, which began four years ago, is an integrated case management system for psychiatric and substance abuse services, offering benefit design, preferred provider plans, and claims review. PHC's Michigan corporate clients include Chrysler (for whom it manages the company's HelpLine program) and, starting in July, General Motors.

PHC's size and influence raise questions in the mind of some state physicians. "These programs are very effective at saving money, but the effect on care? That remains to be seen," says Sheldon Siegel, MD, past president of the Michigan Psychiatric Society, who has long involvement in peer review and credentialing programs. "They manage access in most programs, but the payers also manage benefits by limiting benefits." Doctor Siegel is concerned with the insurer payments that are far below cost and the review programs dovetailing to drive down quality and add an impediment to care. "They claim guaranteed quality, but how can you do this when access by physicians is limited by low fees?"

But those involved in the review process point to strong internal safeguards to ensure fairness and quality. "I think it helps establish our credibility that our standards are published and well known," says Saul Foreman, MD, a PHC regional medical director, corporate vice president, and member of MSMS. "We have a several-level review process, with PROM as the final review, and yes, they have overturned some of our decisions. But if we're uncertain, we'll err on the side of caring for the patient." ■

Ralph Ward is a Lansing-based freelance writer.

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Helping the Elderly Meet Non-Medical Needs

Physicians should take an active role

By James G. O'Brien, MD

The MSMS Committee on Aging, chaired by James G. O'Brien, MD, Lansing, recently learned that elderly patients need assistance from physicians in locating and gaining access to non-medical services, such as home delivered meals, transportation and homemaker services. This need was identified through a survey conducted by the Area Agency on Aging 1-B, a private nonprofit organization responsible for planning, developing, coordinating and funding older adult services in Livingston, Oakland, Macomb, Monroe, St. Clair and Washtenaw counties. Representatives from the Area Agency on Aging presented the findings of its survey to members of the MSMS Committee on Aging at a meeting held in March. A report prepared by the Committee on the survey's findings follows.

A recent survey has found that physicians are very interested in helping their elderly patients locate and gain access to non-medical community resources, either directly or by referring patients to an information and referral agency.

The survey, the first stage of a pilot project developed by the Area Agency on Aging l-B, was designed to ascertain from physicians the following: (1) the type of social services for which assistance is most requested by older adult patients and their families; (2) physician awareness of existing social services for the elderly; and (3) services that physicians and their staff would find most helpful to them in assisting their patients with social service needs.

Before the survey was conducted representatives from the Area Agency on Aging made a presentation to the MSMS Committee on Aging, seeking support and endorsement for the project. "We knew from the very start of this project we wanted and needed input from the medical community," stated Vicki Choate, advisory council member and chair of the ad hoc committee proposing this study. "We felt quite confident based on the initial interest expressed by the review panel which was composed primarily of physicians in the field of geriatric medicine, that the medical society would recognize the value of such a project."

The MSMS Committee on Aging played a vital role by sending a letter of endorsement to the medical societies in the counties selected by the Area Agency on Aging l-B — Oakland and Washtenaw — as pilot sites. Area Agency on Aging staff next met with representatives of the respective county medical societies to discuss what role each party would play in the pilot project implementation.

The survey was conducted last fall. The selection of Oakland and Washtenaw allowed the survey to be conducted in a large, urban area and a small more rural area, in relatively close proximity, to see if regional differences would appear. Another important determining factor was the presence in each county of a centralized county-level information and referral network for older persons. A total of 2,000 surveys were mailed to all members of Oakland and Washtenaw county medical societies rather than to a random sample of the membership. The mailing was not stratified by subspecialty to isolate respondents most likely to be treating a higher percentage of geriatric patients, such as internists or family practitioners. Eleven percent of the surveys were completed and returned. Ninety-four percent of the surveys returned were completed by physicians.

Highlights of the survey findings follow. A complete report is available from the Area Agency on Aging l-B upon request.

A summary of survey findings

Respondents estimated, on average, they receive 41 inquiries a month from elderly patients or family members regarding such matters as arranging long-term care, finding help in managing financial affairs or locating a home maintenance program. As might be expected, the vast majority of inquiries received had to do with health insurance matters i.e., Medicare, Medicaid or third party coverage. The three most prevalent areas of inquiry following insurance concerns were questions about in-home services, home delivered meals and long-term care placement options. Other community services for which information was frequently asked included resources to help with stress or depression including support groups, support services for caregivers of demented or frail homebound elderly, and assistance for individuals with vision or hearing impairments.

Overall, however, except for services with high visibility or with national affiliations such as *Meals On Wheels*, there was a general lack of awareness on the part of the physician of community resources. Of the 21 community services listed, the majority of the respondents were "not familiar" with nearly one-half of the services and only "somewhat familiar" with the remaining services identified. When asked about their familiarity with community services, the physicians were most familiar with home delivered meals followed by specialized transportation services, emergency telephone monitoring devices and personal care services. The respondents were least familiar with the following community services: the long term care ombudsman program, financial management, outreach and legal assistance.

Critical to the issue of access to community resources is knowledge about information and referral programs by both physicians and the elderly. Information and referral is a professional service which provides the caller with the names and phone numbers of one or more community services designed to meet his or her needs. The information and referral service discusses the problem with the caller and identifies available resources in the community. Unfortunately, less than one percent of the respondents were "very familiar" with an information and referral service. Just under half of the respondents (46 percent) were "not familiar" with this service.

Fifty-eight percent of respondents indicated that either the physician or staff do refer patients to the community services identified in the survey. The community services to which referrals were made most frequently were the ones with which they were the most familiar i.e., home delivered meals, transportation and homemaker services. The respondents indicated that referrals were most often made

Continued on next page

Continued from previous page

by hospital discharge planning departments. When a referral was handled by the physician and/or staff frequently it was done in cooperation with a hospital. Those respondents who stated they were not making referrals on behalf of their elderly patients were not doing so because they were not certain where to refer (30 percent). Other reasons for not referring patients included that referrals are made by social workers or referral requests do not come up.

When asked to rank a list of service areas for which additional resources would best facilitate treatments of their geriatric patients, the majority of respondents indicated that a means of comprehensive geriatric assessment would help them achieve this end. The next highest regarded service listed which they felt would be of benefit was nutrition assessment followed by hospice care service for the terminally ill, and then assistance with respect to medication choices and their side effects.

To give physicians and their staff an opportunity to play a more active role in the referral network, a list of options was presented such as using an information and referral service, attending a workshop to become acquainted with community resources and receiving literature on available services. Respondents expressed the highest interest (91 percent) in using a specialized informational and referral phone number on behalf of their patients.

Respondents also were very interested (85 percent) in receiving information about community resources, as well as willing to make literature available in their offices. Respondents were, on the other hand, nearly divided (54 percent) on willingness to attend a seminar or have a staff member attend. Other suggestions offered by respondents to promote physicians' use of the aging referral network included having a directory of community resources available and including information about such programs and services in continuing medical education programs.

The findings of this survey suggest that while physicians could play a vital role in the referral chain and are interested in doing so, the level of awareness of non-medical community services for older adults is, in fact, low.

Changing role of physicians

Traditionally, non-medical needs have not been regarded as within the purview of a physician's responsibility, even though a physician was considered a primary source for health information. Today, however, social and demographic factors are combining forces to change the role of the physician. Namely, modern medicine has prolonged life...the fastest growing segment of the population is over 85.

Apart from the fact that many older persons remain active and independent, older persons are more likely to require personal assistance, and will turn to their physician seeking information on available resources and how to use them. Not surprisingly though, the agencies to which physicians refer are the ones with which they are most familiar. The study also points out that referrals are more likely to occur within, for example, a hospital setting using a discharge planner or social worker as the source of referral. Additionally, the impression emerges that physicians are aware of gaps in the health care delivery system and recognize, for example, the need for comprehensive geriatric assessment.

Finally and perhaps most importantly, survey findings indicate that the majority of physicians are willing to assist in promoting use of available services within the aging network. Physicians also have definite ideas about what would assist them such as having literature about community services available in their offices. Physicians expressed a high degree of interest in learning about these same programs.

Some would argue that assessing non-medical needs is not the role of the physician. Whether it is or not, physicians are being asked to become involved. Consequently, to increase the probability that older patients' non-medical health-related needs will be met, a collective effort between physicians, their staff and the aging network needs to be undertaken to effectively strengthen the linkage.

The Area Agency on Aging 1-B is now working with Oakland and Washtenaw county medical societies on the second phase of this project which is an educational component to assist physicians and their staff in addressing the service needs of their older patients. Additionally, plans call for conducting the survey in the four other counties located within the jurisdiction of the Area Agency on Aging 1-B. "Ultimately we would like to see this project replicated throughout the state," said Vicki Choate. "It's an important step toward improving access, helping to meet needs of older adult patients and provides an excellent opportunity for numerous groups to work together toward a common goal." ■

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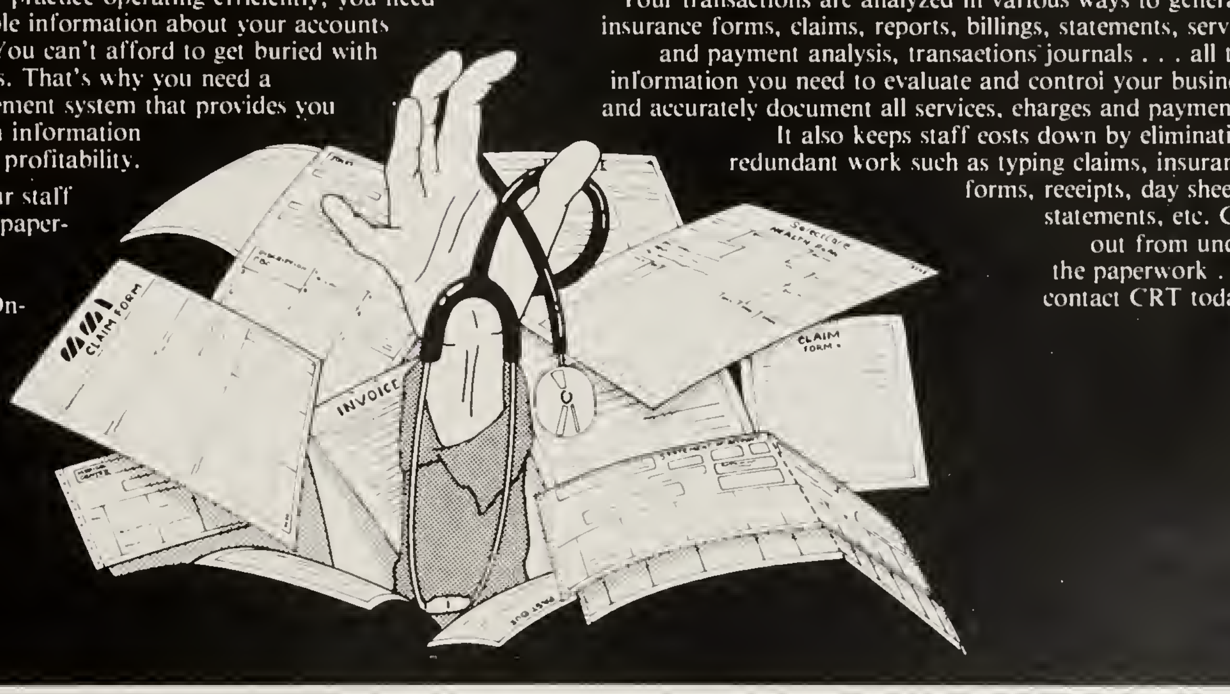

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Board of Medicine Actions

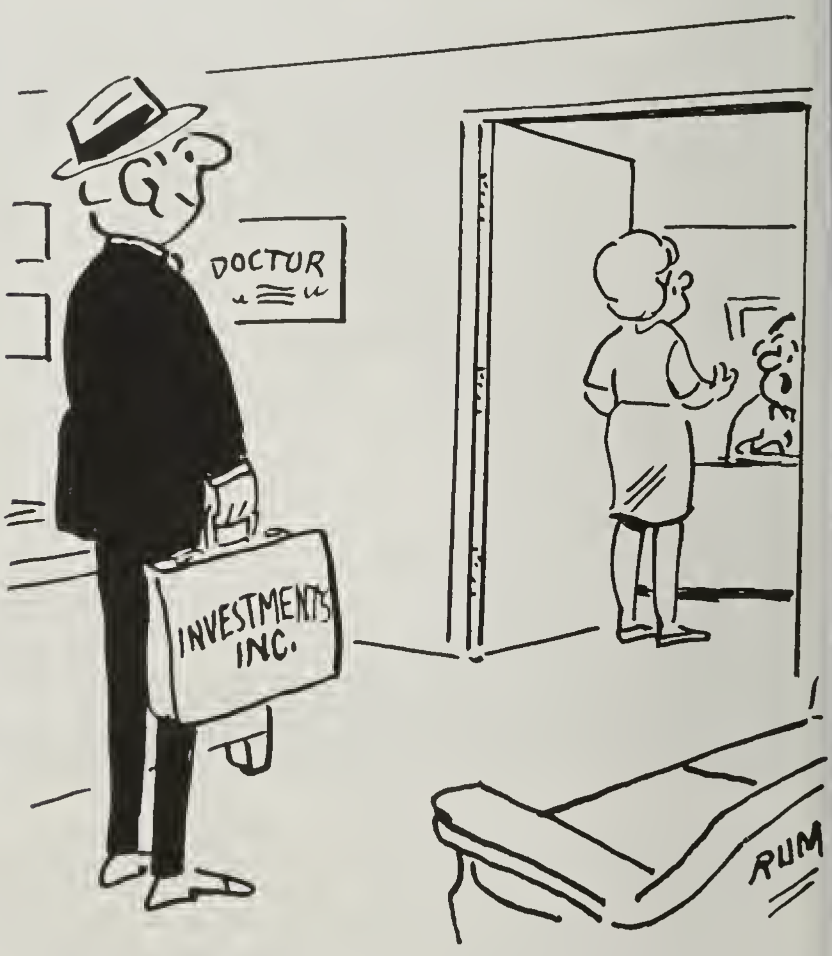
The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Jayantilal J. Bathani, MD, 509 Hazen St., Paw Paw, MI 49079
Action, Date Taken: Suspended; May 3, 1991, Limited License, Fined – $1,000
Reason: Conviction/Violation of Penal Code

Name: David B. Edgar, MD, 1001 Medical Park Dr. SE, Grand Rapids, MI 49506
Action, Date Taken: Limited License; March 20, 1991, Probation 3 years, Fined – $1,000, Reprimand
Reason: Substance Abuse

Name: Edgardo T. Espiritu, MD, 2100 Highway 365, Nederland, Texas 77627
Action, Date Taken: Revoked; March 20, 1991, Fined – $250
Reason: Negligence – Incompetence

Name: Donald B. Garvin, MD, 1420 Center Avenue, Bay City, MI 48706
Action, Date Taken: Suspension 6 months, 1 day; May 3, 1991, Fined – $10,000
Reason: Negligence – Incompetence



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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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2. Standard industry new prescription audit

Please see brief summary of prescribing information on adjacent page.

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy:
Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.
Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:
Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.
Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.
DRUG ABUSE AND DEPENDENCE:
VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.
OVERDOSAGE:
Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.
Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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DEATHS

William C. Montgomery, MD
Birmingham

William C. Montgomery, MD, a pediatrician, died March 15. He was 64. Doctor Montgomery received his undergraduate and medical degrees from Johns Hopkins University. He served his internship at Henry Ford Hospital, Detroit. Doctor Montgomery began his medical practice in Detroit in 1958 and taught on staffs at Wayne State University School of Medicine and Mercy College of Detroit. In 1963, he started another practice until 1970, at which time he became director of pediatric residency at Mount Carmel Mercy Hospital. He held that position until his death. He was a member of the American Medical Association, the Michigan State Medical Society, the Wayne County Medical Society, the Ambulatory Pediatric Association, the Association for Hospital Medical Education, the Association for Care of Children in Hospitals, and the American Academy of Pediatrics.

Matthew Peelen, MD
Kalamazoo

Matthew Peelen, MD, a general surgeon, died April 2. He was 86. Doctor Peelen attended Hope College, Rush Medical College and the University of Chicago. He served as chief of staff at Bronson Methodist Hospital, Kalamazoo. Doctor Peelen, along with his brother J. William Peelen, MD, opened a medical office together in 1935, in Kalamazoo. He was the first board certified physician in that area. He retired in 1980. Doctor Peelen was a member of the Michigan State Medical Society.

Winston B. Prothro, MD
Haslett

Winston B. Prothro, MD, a public health physician, died March 7. He was 79. Doctor Prothro earned a bachelor's degree from Baylor University in 1934, and the University of Arkansas in 1937. In 1939 he received his medical degree from the University of Arkansas School of Medicine, and a public health degree from the University of Michigan in 1948. He served his internship at Charity Hospital, New Orleans. Doctor Prothro worked for the Arkansas Public Health Department from 1940 to 1942 serving as the Director of Public Health. The next three years he served as director of public health of El Paso, Texas. He moved to Kalamazoo in 1945 where he directed the City-County Health Department for seven years. In 1952 he moved to Grand Rapids and became the Health Director for Grand Rapids and Kent County Health Departments for 24 years. Doctor Prothro served on numerous health boards, founding the Kent County Health Council. In 1989 he was awarded for 50 years of practice. He was a Diplomat and a Fellow of the American Board of Preventive Medicine. He was a member of the Kent County Medical Society and MSMS.

William S. Reveno, MD
Southfield

William S. Reveno, MD, an internist, died March 20. He was 94. Doctor Reveno graduated with a bachelor's degree in chemistry and pharmacy from the University of Michigan in 1917. In 1921, he received his medical degree from Wayne State University. He served as associate professor of clinical medicine at Wayne State. He resided on staff at Harper Hospital, Detroit, from 1939 until 1983. He was the former associate editor of the *Detroit Medical News*, and the *Bulletin* of Wayne County Medical Society from 1924 to 1932. He also edited the Harper Hospital Bulletin and earned an award for distinguished service in medical journalism from the American Medical Writers Association. Doctor Reveno was a fellow of the American College of Physicians, the American Thyroid Association and the Detroit Academy of Medicine. He was a member of the Wayne County Medical Society and MSMS.

Victor M. Zerbi, MD
Ypsilanti

Victor M. Zerbi, MD, a general practitioner, died March 8. He was 75. Doctor Zerbi was on staff of Beyer Hospital and served as chief of staff. He had a private practice in the Ypsilanti/Ann Arbor area for many years. He was a member of the American Medical Association, the Washtenaw County Medical Society, a fellow of the American Academy of Family Practice and a member of MSMS.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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610 Main St.
Rochester 48063

Taufiek Alhadi, DO — AN
22421 Cobb
Dearborn 48128

Richard B. Atkins, MD — P
1645 Cass Lake Rd.
Keego Harbor 48330

Taisser Atrak, MD — NEO
2078 Wyndham Hill Dr. #303
Grand Rapids 49505

James D. Bash, DO — FP
2331 Progress St.
West Branch 48661

Carter R. Bishop, MD — IM/HEM
3990 John R #406-4V
Detroit 48201

Barbara J. Boyd, MD — IM/PD
6416 Dean's Hill Rd.
Berrien Center 49102

James F. Butler, DO — CD/IM
252 E. Lovell St. #506
Kalamazoo 49007

James P. Carl, MD — DR
3110 Professional Dr.
Ann Arbor 48103

Gregory D. Casey, MD — GS/TRS
5229 S. Broadmoor
Jackson 49201

Richard K. Clise, MD — FP
1514 Wealthy St., SE
Grand Rapids 49503

William C. Cunningham, DO — EM
1919 Boston, SE
Grand Rapids 49501

Douglas C. Daly, MD — OBG/END
1900 Wealthy St., SE #330
Grand Rapids 49506

Andrew Daugavietis, MD — RHU/IM
1900 Wealthy St., SE
Grand Rapids 49506

George T. Demian, MD — AN
6777 W. Maple Rd.
West Bloomfield 48322

Matthew B. DeWys, DO — IM
1840 Wealthy St., SE #375
Grand Rapids 49506

Tangerine R. DuPuis, MD — FP
2500 7th. Ave. #201
Escanaba 49827

Glen D. Enzenberger, MD — FP
1414 W. Fair Ave.
Marquette 49855

Hesham E. Gayar, MD — RO
4100 Beecher Rd.
Flint 48532

Keith E. Gilmer, MD — RHU/IM
25085 Biarritz
Oak Park 48237

Rahima Spanta, MD — PTH
2290 N. River Rd.
St. Clair 48079

Russell E. Tanner, MD — OBG
25 East M-55
Tawas City 48763

Reid S. Taylor, DO — P
640 Michigan Ave. #103
Holland 49423

Geoffrey M. Thomas, MD — NS
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Ypsilanti 48197

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4870 Bridle Run #2-C
Ypsilanti 48197

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Southfield 48034

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Plymouth 48170

Sharon S. Walker-Watkins, MD
15500 19 Mile Rd.
Mt. Clemens 48044

Mark W. Weiss, MD — R
2565 Bagley
Flint 48504

Alan R. Zarkower, DO — AN
1645 Kirts
Troy 48084

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1535 Gull Rd. #110
Kalamazoo 49001

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Continued on page 59

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Continued from page 56

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MEETINGS

MSMS Meetings

August

12-16, MSMS Practice Management Seminar "Conomikes Medical Office Management." Location: Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

September

11,12,14-15, MSMS Practice Management Seminar "Improving Your Practice Productivity and Performance in the 1990s." Location: September 11, at Hyatt Regency, Dearborn. September 12, at University Club, East Lansing. September 14-15, at Grand Hotel, Mackinac Island, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

13-14, MSMS Practice Management Seminar "Starting Yourself in Medical Practice." Location: Amway Grand, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

October

1,2,3, MSMS Practice Management Seminar "How to Improve Third-Party Reimbursement and Coding." Location: October 1, at Dearborn Inn, Dearborn. October 2, at Bay Valley Inn, Bay City. October 3, at University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

8,9,10, MSMS Practice Management Seminar "ICD-9CM Diagnosis Coding - How to do it Right." Location: October 8, at Grand Traverse Resort, Traverse City. October 9, at Amway Grand, Grand Rapids. October 10, at Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

16, MSMS Practice Management Seminar "Retirement Planning." Location: University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

22,23,24, MSMS Practice Management Seminar "1991 BCBS Medicare Update Series." Location: October 22, at University Club, East Lansing. October 23, at Dearborn Inn, Dearborn. October 24 at Bay Valley Inn, Bay City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24, MSMS Practice Management Seminar "Kerr, Russell, and Weber - Health Law Update (1/2 day)." Location: Regent, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

AMA Meetings

June

23-26, American Medical Association Auxiliary 1991 Convention, The Drake, Chicago, IL. Contact: AMA Auxiliary Headquarters, 515 N. State ST., Chicago, IL 60610.

23-27, AMA House of Delegates Annual Meeting, Chicago Hilton & Towers Hotel, Chicago, IL 60611y. Contact: Jacquelyn Craig, AMA, 515 N. State St., Chicago, IL 60610. 312-464-5000.

National Specialty Society Meetings

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

October

10-13, American Society of Internal Medicine 35th Annual Meeting. Contact: Lisa Derby, (202) 289-1700 ext. 615.

Other Meetings

June

3-4, Henry Ford Health System, Urban Health Care Symposium II. Contact: Donna Trudell, Conference Coordinator, (313) 876-2963.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

June

4,11, The Bar-Levav Educational Association, Ongoing Seminar Series, "Instilling Self Restraint: Another Step in the War Against Narcissism." Sponsor: The Bar-Levav Educational Association. **Contact:** David Fogel, MD, The Prudential Town Center, Southfield, MI 48075, (313) 353-5333. **Approved for: 4 hours Category I Credit.**

5-7, 18th Annual Symposium on Current Topics in Blood Banking. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Dept. of Pathology. **Contact:** Angela C. Voeller, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

10-11, Fifth Annual Cardiology Symposium for Nurses. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Dept. of Cardiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 743-2288. **Approved for:** 12 hours Category I Credit.

13-15, Microscopic Endolaryngeal Surgery: New and Advanced Techniques of Diagnostic Treatment. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

16-19, Eighteenth Michigan Emergency Medicine Assembly. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

17-21, 27th Annual Northern Michigan Summer Conference. Location: Shanty Creek Resort, Bellaire, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O.

Continued on page 65

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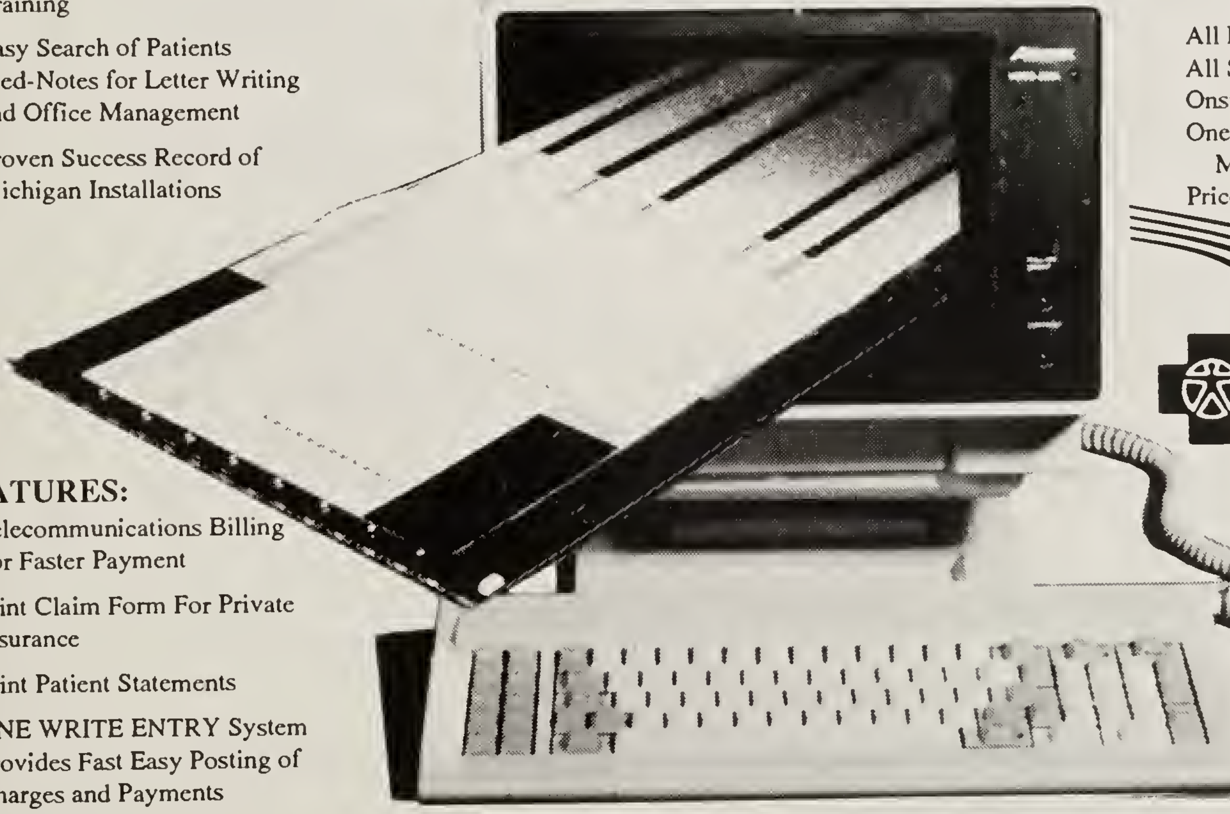

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CATEGORY I COURSES

Continued from page 63

Box 1157, Ann Arbor, MI 48106-9869, (313) 764-2288. **Approved for:** 20 hours Category I Credit.

21,23, Joint Conference for Primary Care Physicians Featuring: Rheumatology, Neurology, Dermatology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** Ingham Medical Center, Department of Continuing Medical Education, and Michigan State University, Department of Medicine, College of Human Medicine. **Contact:** M.A. Taylor, Director, CME, Ingham Medical Center, (517) 334-2107. **Approved for:** 12 hours Category I Credit.

27-29, Clinical Neuro-Oncology Update 1991. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Departments of Neurology, Radiation Oncology, and Surgery, Section of Neuro-Surgery. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869 (313) 936-9800. **Approved for:** 17 hours Category I Credit.

July

8-11, Mackinac Island Imaging Conference. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073 (313) 551-6199. **Approved for:** 21 hours Category I Credit.

14-17, 5th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort, Grand Traverse Village, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48109-9869 (313) 936-1641. **Approved for:** 13 hours Category I Credit.

25-26, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386, (616) 922-9546. **Approved for:** 9-11 hours Category I Credit.

28-31, 17th Annual Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

August

8-11, Cardiology Update. Location: Grand

Continued on page 67

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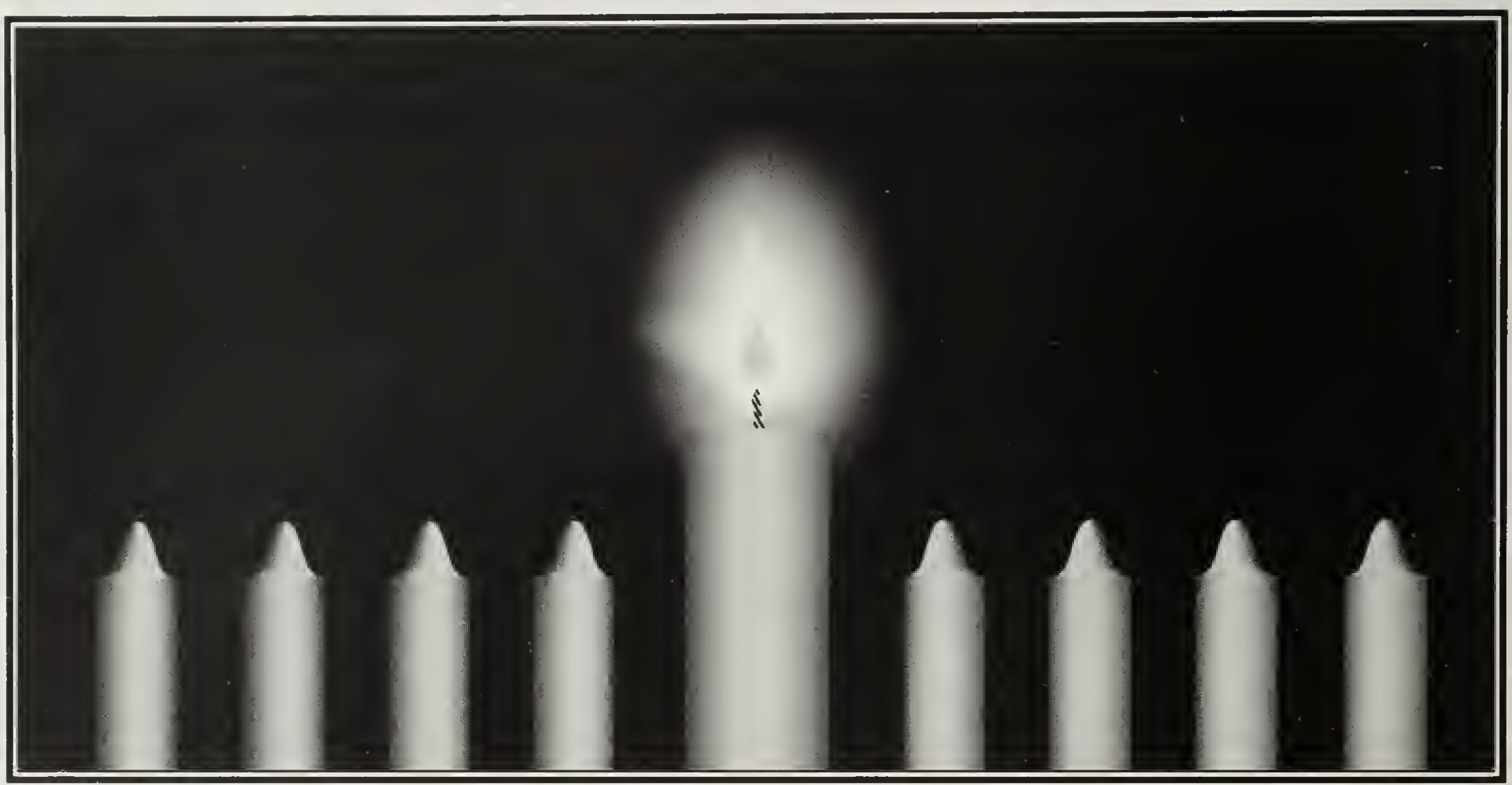

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CATEGORY I COURSES

Continued from page 65

Hotel, Mackinaw Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 12 hours Category I Credit.

10-11, Endocrinology and Diabetes Update. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine and Michigan Diabetes Research and Training Center. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 7 hours Category I Credit.

12-13, Internal Medicine Update. Location: Grand Hotel, Mackinaw Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

15-17, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 13 hours Category I Credit.

September

14, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 6 hours Category I Credit.

October

25-26, Advanced Cardiac Life Support Instructors Course. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians and American Heart Association of Michigan. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 16 hours Category I Credit.

November

14-15, Advanced Pediatric Life Support Course. Location: Children's Hospital, Detroit, Michigan. **Sponsors:** American Academy of Pediatrics and Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

18-19, 15th Annual Michigan Fall Radiology Conference. Location: The Townsend Hotel, Birmingham, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 14 hours Category I Credit.

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with an abundance of lakes, rivers and streams. All are ideally suited for physicians seeking to combine professional excellence in a Midwest, family-oriented location offering exceptional four-season recreational activities. Wisconsin consistently leads the nation in ACT and SAT scores and the school systems in these communities are excellent. Each opportunity offers a superlative lifestyle. Each has its own special qualities with more attractive features relative to individual needs and preferences. Starting salary up to $99,700 with salary in two years up to $131,600. Fringe benefit package is outstanding. If this combination of professional excellence and lifestyle made possible through the back-up resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director of Regional Development, 1000 North Oak Avenue, Marshfield, WI 54449 or call (800) 826-2345 ext. 5376.

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PSYCHIATRY POSITIONS IN INDIANA: Psychiatry recruiting firm is recruiting for four

Continued on next page

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Continued from previous page

staff psychiatry positions in Indiana. State Hospital in Logansport is recruiting three staff psychiatrists to work exclusively inpatient psychiatry. Mental health center in Richmond is recruiting psychiatrist to provide a mix of outpatient and inpatient psychiatry. All subspecialty interests are appropriate. Competitive salary and outstanding fringe benefit package are offered. If interested, please contact Milton Perkins or Michele Puibello at The Pickering Group, Inc.; 11433 N. Port Washington Rd., Mequon, WI 53092. Phone: (800) 752-2464. FAX: (414) 241-8579.

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The Equitable	6
G.D. Searle	BC
Glaxo Pharmaceuticals	64
Harvey Lexus of Grand Rapids	57
Health Plus	57
Interstate Health	4
Kidder Peabody	56
Knoll Pharmaceuticals	51, 52
Lab of Clinical Medicine	8
Manufacturers Bank	22
McDonald & Co.	18
Meade Leasing	49
Medfirst	67
Medical Automation	20
Medical Billing Service	2
Medical Newsletter	67
Medicalis	61
Medsys	52
MPMLC	IFC
Nationwide Collections	55
Palisades Pharmaceuticals	55
PC Medical	53
Pennock Hospital	16
Physician Service Group	1
PICOM	54
Prescott, Ball & Turben	59
Rice Clinic	69
Shearson Lehman Bros.	58
St. Luke's	24, 71
US Air Force	28
US Army	59, 65
Women's Health Center	56

PRESIDENT'S PAGE

Practice Parameters: A help or a threat to medical practice?

By Robert D. Burton, MD

No doubt about it. Practice parameters are the up and coming thing. Like it or not, there's no way to duck them.

The federal government is demanding them. Third party payers are demanding them. That's reality.

But maybe practice parameters are not really the evil "cookbook" medicine that some would have you believe. Maybe we should look at how to best affect this coming reality to get the most out of it.

My personal experience with practice parameters is mixed.

On the positive side, two years ago we otolaryngologists worked with the two physician insurance companies in an effort to define our practice patterns. Because we found most otolaryngologists were not doing facial plastic surgery, we were able to convince the insurance companies to give us a 20 percent cut in our premiums. This clarification of our practice patterns, though it was not in the true sense the development of parameters, turned out to be a nice bonus.

Nationally, the anesthesiologists have reaped great reward for their efforts in developing practice parameters several years ago. The number of lawsuits against anesthesiologists has dropped precipitously as have their liability insurance premiums.

On the down side, several years ago specialty societies worked with the University of Michigan to develop practice parameters. Again, I was on the panel for otolaryngologists. The results were published in a booklet and circulated to physicians. The hew and cry was "Ban it, burn it!" Which we did. The fear was that this "cookbook" would become the gospel for treating patients and that any deviation could and would be used against physicians in a court of law.

Just another resource

The goal of the American Medical Association in the development of practice parameters, however, is to write them and use them as guidelines. They would simply be another resource; the compilation of information and knowledge the medical profession has developed up to this point about a given condition.

The parameters would be taking a great fund of knowledge and putting it in a more useable form. Practice parameters should not be the Ten Commandments, just another way of determining what is good medical care.

Practice parameters are not something new. We've called them other names. We've called them textbooks. We've called them our professors' wisdom or opinions. They've always been there. The process is just more explicit now.

Well written practice parameters will leave room for individual physician decision making. No one is smart enough to account for all the circumstances physicians might find themselves in with particular patients. Patients are all different. Patients as individuals are different at different times. The resources available might vary.

Security a bonus

If done right, practice parameters will offer the practicing physician the ability to feel more secure in patient management decisions and to feel more secure in the area of liability. The parameters will have been evaluated in a scientifically rigorous way and will have been tempered by the clinical judgments of experts in that specialty area, as well as cross-examined by experts in other specialties. If the physician looks at the parameters and then modifies a suggested treatment, such a course of action should be recorded in the office notes or hospital record. If litigation does result, others can see that the physician did consider the parameters.

Practice parameters should not become something to fear in the case of a lawsuit. They should support a physician's good judgment. If the physician can show he or she considered the parameters, and considered the uniqueness of the individual, and then made the best decision based on that information, the practice parameters, in fact, should be a good defense. The record will show that the physician exercised reasonable care by consulting the practice parameters and that there was no negligent conduct in providing the best possible care for that individual.

In the case where a physician does not follow the practice parameter, the plaintiff attorney will argue that he or she had the parameter and didn't follow it. But again, from the onset, we must make certain that it is understood by the courts, by the legal profession, by everyone, that these practice parameters are a compendium of knowledge to be used as guidelines. They are not the absolute "cookbook" on treating every condition. If the physician can show he or she considered the parameters, they should be a defense.

MSMS currently is inventorying practice parameter development by specialty societies in Michigan. MSMS already is working with the otolaryngologists and, before the year is out, we plan to work with family practitioners, general surgeons and neurologists. We hope to coordinate involvement of Michigan physicians in practice parameter development by national specialty societies and the AMA. Interested physicians or specialty societies should contact MSMS.

There really isn't any way we are going to reverse the trend toward parameters. So the best strategy seems to be to make them work *for* us and, above all, for the benefit of our patients. It's better to maintain control of practice parameter development through specialty societies than have government appointed groups do it for us.

Doctor Burton is MSMS president.

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MICHIGAN MEDICINE

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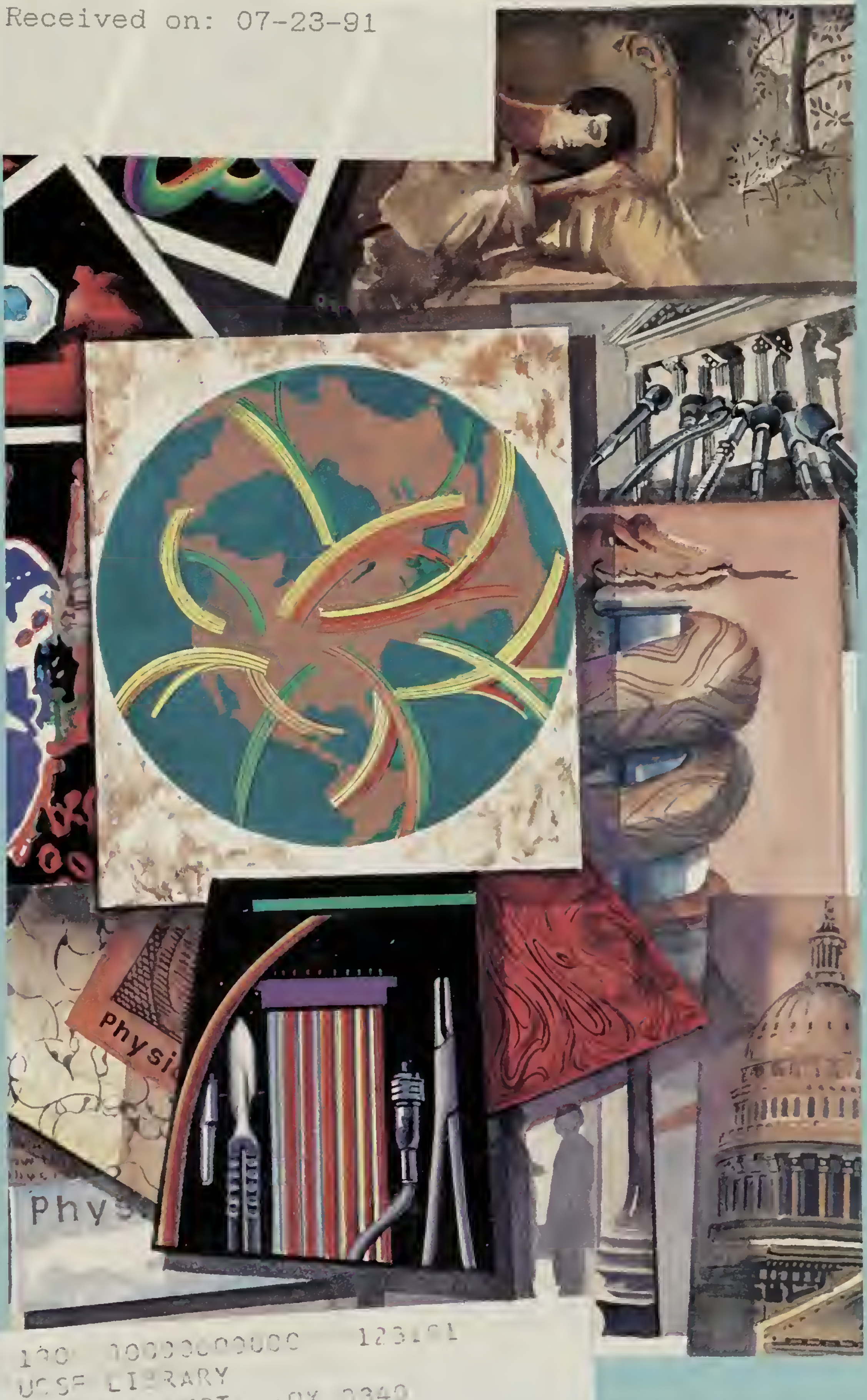

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MICHIGAN MEDICINE

14 COVER STORY

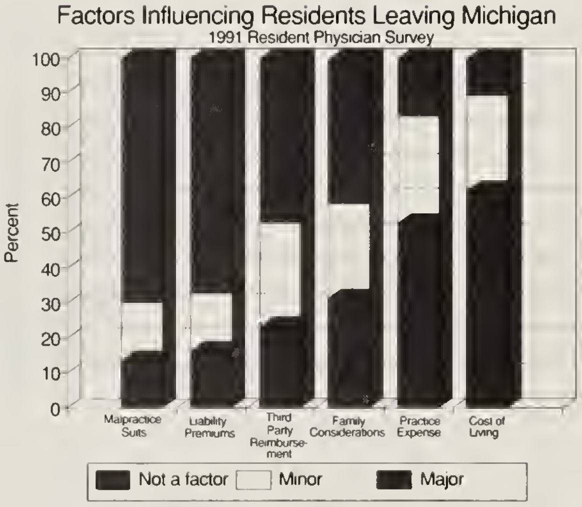
Increased competition and pressures to hold down medical care costs make it imperative that physicians understand and take an active role in the running of their practices. So says Billy Ben Baumann, MD, president of Physician Service Group, Inc., who begins this month's cover story on practice management. As Doctor Baumann explains, MSMS and its subsidiary, Physician Service Group, Inc., devote themselves to providing information about the business side of medical practice. This month's cover story offers an array of information on key practice management topics including electronic claims processing, personnel management, connectivity (the development of a national health care information network), office risk analysis, and payment reform. Rounding out the cover story is a feature on the Michigan Medical Group Managers Association.

Page 14

FEATURES

35 MEDICAL INQUIRER

This is the fifth in a series of factsheets prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. Topic of this Inquirer is resident physician attitudes toward practicing in Michigan.



Page 35

38 INDOOR AIR POLLUTION

Indoor air pollution is far more intense, and more common, and presents greater hazards for health, than almost any pollution hazard encountered out of doors. This feature alerts physicians to the causes of indoor pollution and its hazards to humans.

—BY RALPH WARD

41 MEDICAL WASTE REGULATIONS

This article provides a detailed explanation of Michigan's Medical Waste Regulatory Act of 1990 — and serves as a reminder to physicians that they must comply with the regulations set forth in the Act. Also included is a sample waste management plan.

—BY LAWRENCE CHADZYNSKI, RS, MPH

51 AMICUS COURT CASES

MSMS has expressed its views to Michigan's appellate courts on a number of legal issues of importance to Michigan physicians. This feature provides a brief synopsis of the cases in which MSMS has participated over the past six years.

—BY RICHARD D. WEBER AND JEANNE GEHA SWANSON

55 LEELANAU MEMORIAL HOSPITAL

This feature is presented by the MSMS Task Force on Rural Health Care as an example of how one small rural Michigan hospital is meeting the challenge of change.

—BY JAMES A. KOLBERG, MD, JAMES PACKARD AND BRIAN KASER

59 SPECIALTY SOCIETY SERIES

This third in a series of articles on specialty societies in Michigan examines the challenges facing Michigan's internists.

—BY RALPH WARD

DEPARTMENTS

7 MSMS "On The Move"
9 Newsfronts
10 Physicians in the News
61 New Members
62 Category I Courses
64 Meetings
68 Classifieds
73 Advertising Index
74 President's Page
"Medical ethics through the ages"
BY ROBERT D. BURTON, MD

Page 51

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MSMS House of Delegates Proceedings

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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MSMS On The Move

A MONTHLY UPDATE OF KEY MSMS ACTIVITIES

1991 MSMS Health Legislative Agenda

Professional liability, Medicaid reform, physician licensure and discipline, access to health care, Blue Cross Blue Shield of Michigan, and peer review are some familiar phrases to physicians. MSMS has incorporated these issues and others into its legislative agenda, outlined in a brochure titled "1991 MSMS Health Legislative Agenda." The brochure recently was mailed to residents, legislators and others to increase awareness of what's important to physicians and what changes are needed.

Durable Power of Attorney

A simple do-it-yourself Durable Power of Attorney Health Care form that will help physicians carry out the wishes of their patients is now available to both physicians and the general public. MSMS, the Michigan Hospital Association, the Michigan Association of Osteopathic Physicians and Surgeons, and the State Bar of Michigan announced the form's availability at a May 28 news conference in Lansing. Michigan residents can use the form, which the coalition hopes will become a statewide standard, to designate another person to make medical treatment decisions for them.

MSMS has made the forms available to physicians for distribution to their patients. A sample was published in the April *Michigan Medicine* and order forms were printed in recent issues of *Medigram*. To obtain copies of the form or for further information, call the Communications Department at MSMS.

Risk Management

MSMS and the Michigan Physicians Mutual Liability Company have designed a seminar, "Closed Claim Review Sessions," to help physicians explore risk management issues by looking at closed medical malpractice claims. Through group discussion of the outcome of actual cases, physicians can gain tips on what they can do in their practices to avoid malpractice suits. July sessions focus on closed claims in surgery and August sessions will feature closed claims in general. For a complete list of dates and locations of the sessions, or for further information, call Julie Smith at MSMS.

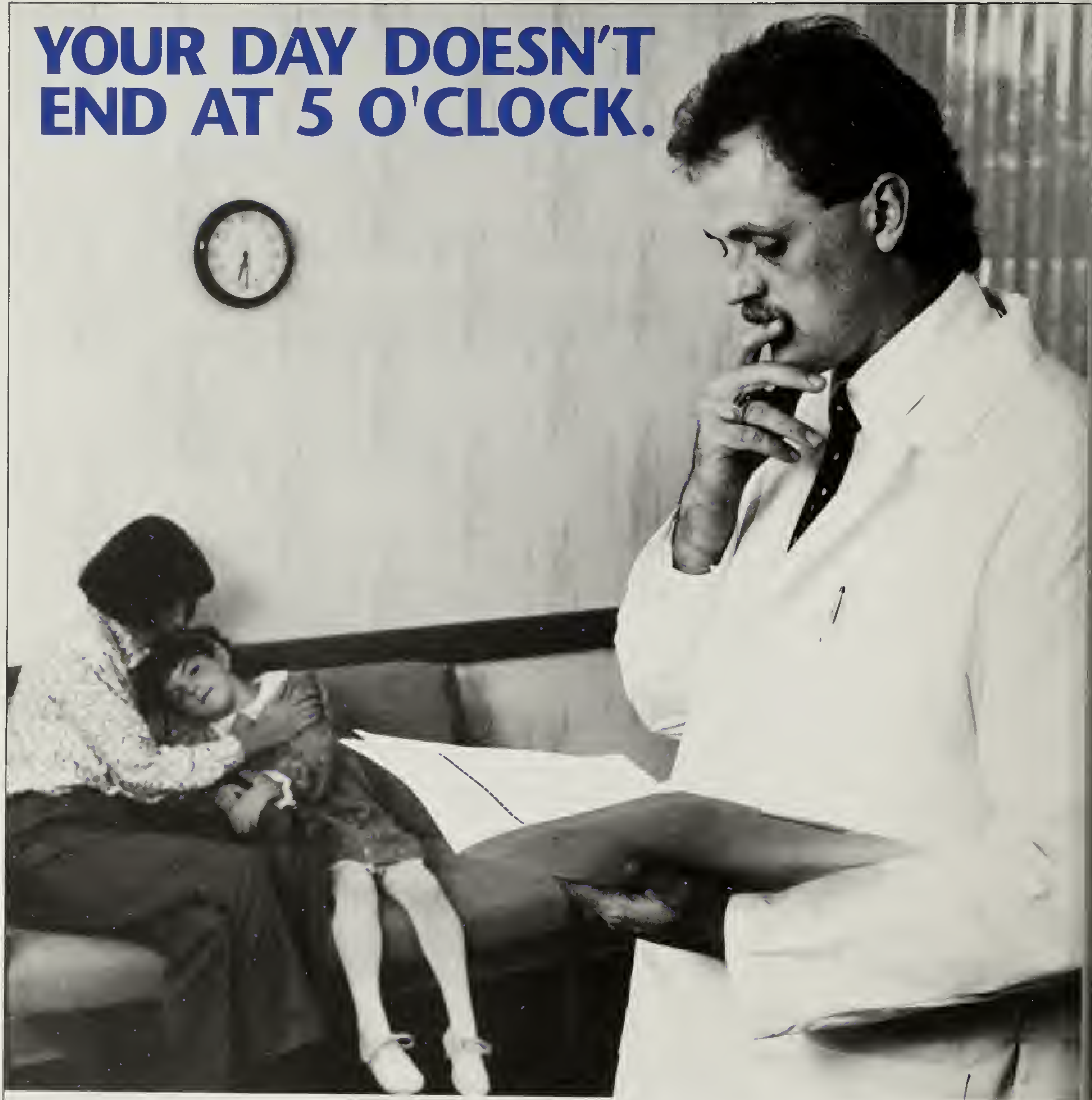
Practice Management

In its continuing effort to present practice management programs for physicians and their office staff, MSMS is presenting its Medical Office Management Institute Aug. 12-16 in Traverse City. The program is geared to teach managers, supervisors and office staff effective personnel management, patient flow management and coding and reimbursement. Watch for a July mailing announcing more than 30 other programs being offered by MSMS this fall. Contact the MSMS Office on Physician Education at (517) 337-1351 for more information.

Voluntary Assignment

MSMS, through its Committee on Aging, recently aided the Calhoun County Medical Society in its successful effort to start a voluntary assignment program for senior citizens in Calhoun County. The result was "Senior Care Plus!" Participating physicians agreed under this program to accept Medicare's allowed charge as payment in full for certain services. MSMS also has helped other county medical societies set up successful voluntary assignment programs in Midland, Clare, Gladwin and Kalamazoo counties. Several other counties have similar programs in the works. For further details, contact Tom Plasman at MSMS.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.



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MEDICAL NEWSFRONTS

INDEX

WSU researchers report successful treatment for esophageal cancer 9

Bronson to support heart disease prevention study 9

Outlook may improve for heart transplant patients, Henry Ford reports 9

U-M biochemist develops "fountain of youth" for old proteins 10

Management program and drug help reduce C-sections, Beaumont reports 11

Harper/WSU conduct diabetes study 11

Grants to be awarded for kidney research 11

Annapolis offers new surgery for Carpal Tunnel Syndrome 11

Pain Therapy Center opens in Detroit 12

Geropsychiatric unit opens at Harper Hospital 12

WSU researchers report successful treatment for esophageal cancer

A discovery recently reported by Arnold M. Herskovic, MD, professor of radiation oncology at the Wayne State University School of Medicine, might provide hope for patients suffering from cancer of the esophagus. The conclusion of a five-year study led by Doctor Herskovic demonstrated significantly improved results when using combined radiation and chemotherapy compared to radiation alone in the treatment of esophageal cancer.

In 1986, the RTOG, in cooperation with the Southwest Oncology Group and the North Central Tumor Study Group, initiated a randomized study designed to test whether radiation of moderate dose with chemotherapy was superior to a higher dose of radiation alone.

Analysis of the 121 available patients in Herskovic's study revealed a significant advantage for the combined treatment arm as measured by median survival. Furthermore, patients on the combined arm had fewer local and distal recurrences.

Doctor Herskovic serves as vice-chairman of the Gershenson Radiation Oncology Center at harper Hospital in the Detroit Medical Center. Professors of internal medicine, Muhyi Al-Sarrah, MD, and Vainutis Vaitkevicius, MD, also participated in the study.

Bronson to support heart disease prevention study

In a major, five-year initiative to help combat heart disease, Bronson Methodist Hospital, Kalamazoo, is joining with WWMT and the Kalamazoo Chapter of the American Heart Association of Michigan in sponsoring a five-year study aimed at making individuals aware of their own risks for heart disease.

The National Heart Attack Risk Study is a privately-funded, nationwide program under the direction of William Roberts, MD, editor of the *American Journal of Cardiology.* Its goal is to help 500,000 Americans improve their cardiac condition over the next five years by learning their five modifiable risk factors for heart disease and taking action to make lifestyle changes to reduce those risk factors. It is the largest study of its kind and the first to target all five modifiable risk factors for both men and women in geographically diverse areas and track changes over a five-year period.

Regionally, the Heart Attack Risk Study will take place as follows. Bronson Methodist Hospital will conduct evaluations at several study sites throughout the year for the general public, at area businesses, for its own employees and at various sites throughout southwest Michigan.

Each participant will receive an evaluation of five key modifiable risk factors. They are: smoking, cholesterol, blood pressure, weight, and blood sugar (diabetes). The initial evaluation will be conducted free of charge.

Each participant will meet individually with a nurse at the study site to review personal risk factors and receive educational material and information to make necessary changes to modify risk factors. Those who score at high risk, according to study criteria, will be referred to their physician. All participants will be encouraged to return every six months, for a minimal fee, over a five-year period to be re-checked.

The Heart Attack Risk Study is one of a series of community directed health promotion campaigns by Bronson aimed at improving individual health. "In terms of our overall promotional efforts, we are making a commitment to provide people with the health information they need to know to manage their own health destinies," said Bronson President Patric E. Ludwig.

"We feel this is a cost-effective, responsible use of our resources as a total healthcare provider," he added. "The community has indicated their desire for lower health care bills. In addition to our efforts to lower prices for our hospital services, we also have a responsibility, as a leader in health education, to help keep our community healthy. The least expensive form of health care treatment is prevention."

Outlook may improve for heart transplant patients, Henry Ford reports

Henry Ford Hospital has been approved by the US Food and Drug Administration as one of 15 clinical investigation sites for an implantable device that offers critically ill patients who are awaiting heart transplants a much better chance at survival.

"We think this is the beginning of a new era for the surgical treatment of endstage heart disease," according to Arthur Dresdale, MD, surgical director of Thoracic Surgery at Henry Ford Hospital and principal investigator for the study.

The device under study...called an air-driven HeartMate ventricular-assist device (VAD)...was designed to support the natural heart when the left ventricle has been weakened.

"This device will offer a bridge to patients while they wait for a donor heart to become available," said Doctor Dresdale. "Because donor hearts are increasingly in such short supply, these patients often require support for periods ranging from weeks to

Continued on page 10

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months. With this device, many individuals who would probably have died waiting will now have an opportunity to survive long enough to receive a life-saving heart transplant.

"We also hope these early studies will prove to be the beginning of a new era in which left ventricle assistance devices will become an alternative to heart transplants for selected patients," added Doctor Dresdale.

Currently, about 30 percent of potential heart transplant patients die before a donor heart becomes available. An estimated 50,000 people every year could benefit from long-term cardiac support.

U-M biochemist develops "fountain of youth" for old proteins

A University of Michigan biochemist has discovered how to rejuvenate aging proteins...restoring youthful structure and function...by soaking them in a special type of saltwater bath.

Ari Gafni, associate professor of biological chemistry in the U-M Medical School and associate research scientist in the U-M Institute of Gerontology, says he also has discovered how to protect one type of protein enzyme against aging by chemically blocking two amino acids on the enzyme's surface.

Gafni emphasized that reversing aging in proteins is a long way from reversing aging in humans. But he says understanding how and why proteins age is an important first step.

"By analyzing the aging process in specific protein enzymes, we've learned that protein aging and the reduced enzyme activity associated with aging is not caused by genetic defects or mutations, but by structural changes that occur after protein synthesis," Gafni said.

Gafni directs one of less than a dozen research projects in the United States studying molecular aging, and the only project involving collaboration with physical scientists. Duncan G. Steel, U-M professor of physics and electrical engineering and computer science and research scientist in the U-M Institute of Gerontology, developed advanced laser spectroscopy techniques that he uses to identify subtle changes in the molecular structure of protein molecules as they age.

"With laser spectroscopy, we can monitor changes in proteins as they occur," Steel said. "Lasers can probe the microscopic details of protein binding sites, which are often affected by the aging process."

Gafni and Steel's current research focuses on the enzyme phosphoglycerate kinase (PGK), which helps a cell metabolize glucose.

Gafni discovered that older PGK molecules fold differently than younger ones. PGK tends to "relax" as it ages, changing several enzyme properties. When Gafni soaked old PGK in a specially formulated salt solution, it relaxes completely to form an unfolded chain of amino acids. Once the salt was washed away, PGK refolded into its original "young" configuration, restoring 100 percent of its functional activity.

"In later experiments, we succeeded in producing a young form of PGK that is immune to aging," Gafni said, "by artificially blocking two cysteine amino acids that are located next to each other in the molecular structure. This leads us to believe that cysteine oxidation is somehow essential to the aging of PGK."

Gafni and Steel hope to expand their research to study proteins in living organisms. "Many genetic diseases produce structural changes in proteins," Steel said. "This research has the potential to

Physicians in the News

Eli M. Brown, MD, chairman, Department of Anesthesiology, Sinai Hospital, is the winner of the William O. McQuiston, MD, Award, which is presented annually to an anesthesiologist with a national education who has made significant contributions to the practice of anesthesiology. The first physician from the state of Michigan to receive this honor, Doctor Brown was selected from a group of prominent anesthesiologists. The honor is sponsored by the Illinois Society of Anesthesiologists and is presented annually.

Caroline Florescu, MD, who turns 60 in November, is the oldest student to graduate in the history of the Wayne State University School of Medicine. She received her medical degree along with 260 other students, June 7. Dr. Florescu started residency training at Sinai Hospital July 1.

Robert P. Lisak, MD, a Bloomfield Hills neurologist, is recipient of the Doctor's Award from the National Myasthenia Gravis Foundation, which is given annually to only one doctor nationwide. The Doctor's Award is granted to a doctor who has made extraordinary efforts, beyond financially-compensated medical services, to assist myasthenics or activities in pursuit of the conquest of myasthenia gravis, including research, patient services, professional education, lay education, fundraising and administration. Doctor Lisak's interest in and commitment to Myasthenia Gravis began in 1964, when he received the Henry R. Viets Traineeship while a medical student at the College of Physicians and Surgeons of Columbia University, New York. Since then he has been involved in scientific research with a long-term goal of finding a cure for the disease.

W. Patrick Mazier, MD, a Grand Rapids surgeon, is the new president-elect of the American Society of Colon and Rectal Surgeons. Doctor Mazier is president of the Ferguson Clinic, on the Board of Trustees of Ferguson Hospital Foundation as well as a Board member of the Kent County Medical Society and the Kent County Unit of the American Cancer Society. Earlier this year Doctor Mazier was featured in *Good Housekeeping* magazine as one of the 400 Best Doctors in America and was featured in an article on leading physicians in the June issue of *Grand Rapids Magazine.*

The American College of Surgeons recently held its Annual Coller Competition in East Lansing. The following awards were presented: *Frederick A. Coller Awards:* **Margaret Schnitzler, MB, BS,** Ferguson Hospital, Grand Rapids; **Kenneth R. McCurry, MD,** University of Michigan, Ann Arbor; **Madhu Prasad, MD,** Wayne State University, Detroit. *Robert Danto Memorial Award:* **Jonathan M. Roberts, MD,** Henry Ford Hospital, Detroit. *Michigan Committee on Trauma, American College of Surgeons:* **Jon McLaughlin, MD,** Butterworth Hospital, Grand Rapids. ■

Continued from page 10

someday give us insight into how to stabilize proteins and make them ore resistant to structural damage."

Gafni and Steel's research has been funded by the National Institutes of Health, the National Institute of Aging, the American Heart Association of Michigan, the Kellogg Foundation, the American Federation for Aging Research, the Office of Naval Research and the U-M.

Management program and drug help reduce C-sections, Beaumont reports

Active management of labor using intermediate-level doses of oxytocin, a labor-stimulating drug, significantly lowered the rate of Cesarean-section births in first-time mothers at William Beaumont Hospital, Royal Oak.

In a prize-winning paper presented at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in May, Beaumont Hospital doctors reported a 32 percent reduction in C-section births among pregnant patients delivering their first babies. The reduction was achieved with an Active Management of Labor (AML) program using intermediate doses of the drug oxytocin.

Patients in the study included 200 first-time mothers treated through the hospital's obstetrics clinic from October 1989 through September 1990. The patients were in active labor when the drug was administered, with uterine contractions less than ten minutes apart and either spontaneous ruptured membranes or 90 percent cervical effacement. Oxytocin was used only if labor failed to progress during a two-hour period.

Methods and criteria for Active Management of Labor programs, including the use of oxytocin, were introduced in the late 1960s at the National Maternity Hospital, Dublin, Ireland. One obstacle to the widespread use of these programs in this country has been the relatively high dose of oxytocin prescribed in the Ireland protocol.

In the Beaumont study, doctors used one-third of the dose called for in the Ireland protocol, showing that lower doses are effective in reducing C-section rates.

"Oxytocin can be used safely, and our program could be used in any institution to reduce Cesarean-section rates, said Leo Gerhardstein, MD, who presented the study results at the scientific meeting. "It doesn't require sophisticated equipment, and the protocol is easy to follow."

In addition to Doctor Gerhardstein, collaborators in the Beaumont study included obstetrics resident Matthew T. Allswede, MD, staff perinatalogist Chris T. Sloan, MD, and Robert P. Lorenz, MD, Vice-Chief of Obstetrical Services of the hospital's Department of Obstetrics and Gynecology.

Harper/WSU conduct diabetes study

Approximately 50,000 diabetics have leg amputations every year which can be prevented with aggressive treatment of leg and foot ulcers. Harper Hospital/Wayne State University researchers are conducting a study involving a medication that may heal foot and leg ulcers associated with diabetes. The principal investigator of the study is Solomon Rosenblatt, MD, director of the diabetes foot care program at Harper Hospital and assistant professor of internal medicine, Wayne State University School of Medicine.

During the 12-week study, half the participants will receive the topical medication, Recombinant Human Basic Fibroblast Growth Factor (BFGF), and the other half will receive a placebo medication. To be eligible for the study individuals should meet the following criteria:

- Patients must be diabetic and have a lower extremity ulcer (excluding toes).
- Participants must have a stable or deteriorating ulcer for a minimum of four weeks.
- Individuals must be 18 years of age or older and females must not be pregnant.
- Patients must not be involved in any other investigational drug or device study.

Qualified participants will receive two comprehensive physical examinations before and after the study including eye examinations. The medication will be applied twice per week with safety and effectiveness of the treatment being evaluated at each visit.

Medical examinations, laboratory tests and medications associated with the study will be provided free of charge. For further information, please contact Lily Unroe, DPM, clinical research coordinator, diabetes program at (313) 745-3050.

Grants to be awarded for kidney research

Approximately one million dollars in new grants will be awarded for kidney research worldwide in 1991 by Baxter Healtcare Corporation's Renal Division. Baxter has set November 15, 1991 as the deadline for submission of Requests for Proposals (RFPs) for the sixth round of its Extramural Grant Program (EGP).

Two categories of research will be funded in this round: 1) The Preservation of Residual Renal Function and 2) The Dialysis Patient and Nutrition.

Baxter has committed 4.5 million in grants to 52 international researchers since the EGP began in 1989.

The RFPs are reviewed by a distinguished independent Medical Advisory Board comprised of the world's leading renal research scientists. Review criteria is based purely on the scientific merit of the proposed research.

Modeled after the National Institutes of Health research program, the EGP has two funding cycles per year. RFP's for this year's first cycle will be accepted until the April 12, 1991 deadline. The two categories to be funded in this additional round are 1) Beta-Microglobulin Amyloidosis and 2) Open category. The Open category offers scientists working in all areas of renal research the opportunity to submit grant requests.

For more information or to forward completed grant requests, contact Lee Henderson, MD, FACP, executive director, Extramural Grant Program at (708) 270-5200 or at Baxter Healthcare Corporation, Renal Division, Route 120 and Wilson Road, Round Lake, IL 60073.

Annapolis offers new surgery for Carpal Tunnel Syndrome

Rajesh Bhagat, MD, a physician at Annapolis Hospital, Wayne, is one of the first physicians in Michigan to perform a new surgical technique to treat Carpal Tunnel Syndrome.

The new procedure requires a much smaller incision than traditional treatment, and allows patients to recover and return to work almost immediately. The new procedure offered by Doctor Bhagat requires only a tiny incision at the base of the palm, near the wrist. From this incision an "endoscope" is inserted. The endoscope opens the carpal tunnel and relieves compression of the nerve from beneath the skin. No splinting after surgery is necessary, and most regular

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activities can be resumed almost immediately. Patients generally can return to work within one to two weeks.

Pain Therapy Center opens in Detroit

Detroit Riverview Hospital (DRH) announces the opening of the Pain Therapy Center for Southeastern Michigan April 29, 1991. Pain Therapy Center is a comprehensive, interdisciplinary pain treatment program offering services aimed at the functional restoration of individuals struggling with pain and work disabilities. It provides services in a cost effective and "care effective" manner which return patients to productivity.

"Detroit Riverview Hospital is fulfilling a great need for comprehensive pain and work recovery programs locally," said David J. Ameen, DRH administrator. "The Detroit area has a large number of workers in manufacturing and other industrial companies which are notorious for a high incidence of work related injury."

Pain Therapy Center for Southeastern Michigan services include:

- acute and chronic pain management
- headache management
- medical and psychological evaluations
- work recovery and reconditioning program
- vocational counseling
- physical therapy and reconditioning
- education programs
- dietary management
- medication reduction/elimination
- individual, group, and family counseling
- relaxation therapy
- biofeedback

John Ingall, MD, FRCS, FACS, medical director, and expert in pain management and Jill Mushkat, PhD, program director, who brings 10 years of pain management experience will manage the program. Pain Therapy Center for Southeastern Michigan is established as a network member of nationally known Pain Therapy Centers of Greenville, SC.

Geropsychiatric Unit opens at Harper Hospital

Harper Hospital in the Detroit Medical Center announces the opening of a new Geropsychiatric Program. It will deliver short-term hospital care, with skilled, professional nursing care, for the purposes of assessment, diagnosis and intensive treatment of acute psychiatric problems in patients 65 years and older.

"We recognized the need for psychiatric care for older adults, who are currently the fastest growing age group in our country, and developed a program which we believe will meet the needs of the community," said Alan Rosenbaum, MD, medical director of the new program. As people live longer, the stresses of daily living can cause problems, often resulting in a need for psychiatric care.

Treatment plans are individualized and developed by a multidisciplinary team whose goal is to restore the patient to an optimal level of functioning. Patients are guided toward maximizing their abilities as rapidly as they are able. The goal is to return the patient to the community as soon as possible.

The geropsychiatric unit is located at Harper as part of the psychiatric division, with close ties to the comprehensive gerontology program offered by the Detroit Medical Center. This addition will enhance the DMC's ability to provide an integrated continuum of success spanning all levels of care. ■

Michigan State Medical Society

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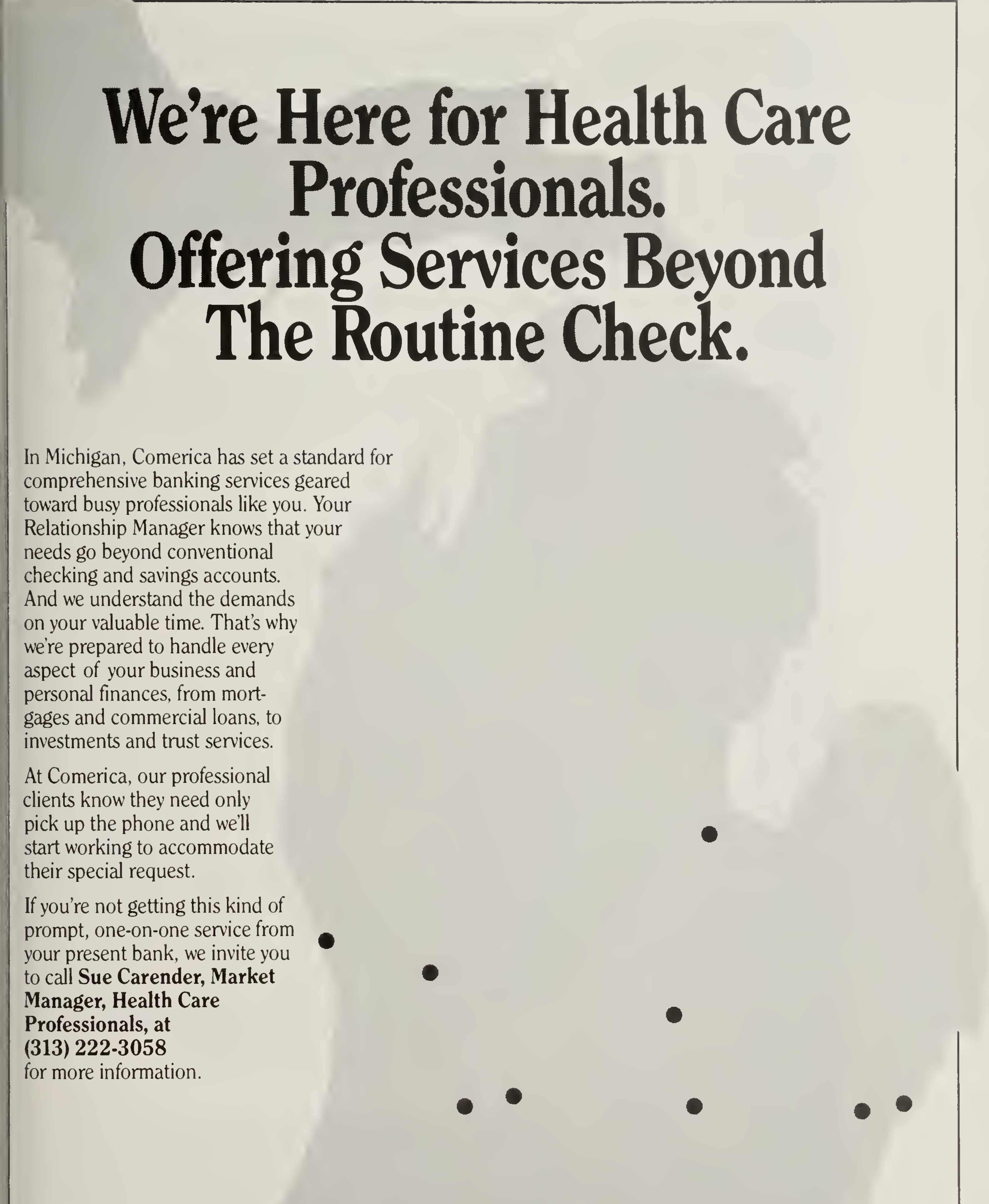

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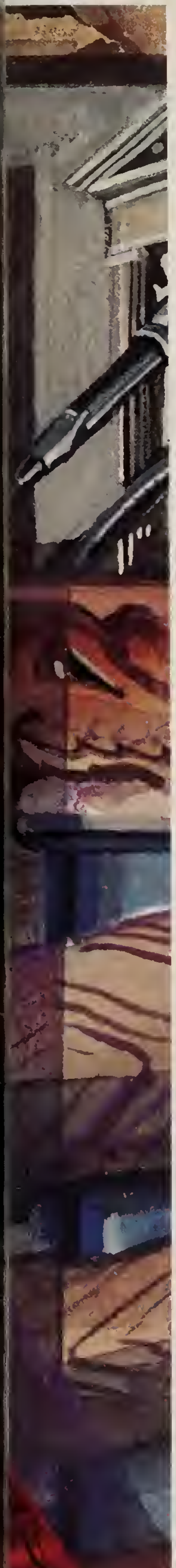

Cover Story

THE BUSINESS OF MEDICINE

Increased competition and pressures to hold down medical care costs make it imperative that physicians understand and take an active role in the running of their practices. So says Billy Ben Baumann, MD, president of Physician Service Group, Inc., who begins this month's cover story on practice management. As Doctor Baumann explains, MSMS and its subsidiary, Physician Service Group, Inc., devote themselves to providing information about the business side of medical practice. This month's cover story offers an array of information on key practice management topics including electronic claims processing, personnel management, connectivity (the development of a national healthcare information network), office risk analysis, and payment reform. Rounding out the cover story is a feature on the Michigan Medical Group Managers Association. A monthly column on practice management issues will be featured in *Michigan Medicine* beginning in September. We hope you find the information provided in this month's cover story informative and useful. ☞

Physicians must take an active role in the running of their practices

By Billy Ben Baumann, MD
President, Physician Service Group, Inc.

If we physicians are to survive and provide good care to our patients in this decade, we will need to *pay attention to business* as never before. Increased competition and the pressures on the cost of medical care will make it imperative that physicians understand and take an active role in the running of their practices. Many of us will be saying, "Oh no, one more thing I have to pay attention to, when all I really want to do is practice good medicine."

I believe that by running an efficient practice, physicians can make a major contribution to both patient care *and* to cost containment. Those physicians who simply do not want to be involved in this aspect of medicine, will increasingly opt for salaried positions, or positions in large groups that have turned over the day-to-day business aspects of the practice to professional managers. Still, for the majority of physicians, the requirement exists to be both a good clinician and a good business person.

In order to accomplish this dual role, we will need to have information available about the business side of the practice as well as the advice of individuals who can assist in making correct management decisions. Often, it is more important for a physician to spend time evaluating individuals who can give them advice and provide information, than it is actually to select products and services for their practice.

MSMS on the move

MSMS and its subsidiary, Physician Service Group, Inc. (PSG), devote themselves to providing information about the business side of medical practice.

MSMS recognizes that physicians generally pass through several phases in their professional careers. These phases include the young physician just entering practice with an idea of either establishing an independent practice, or joining a group; the established physician who is interested in building his practice and devoting the maximum amount of time to patient care within an efficient office context; and, a third phase when an established physician decides to retire or close out the practice. There are also many other phases such as: a physician leaving a group or a private practice (moving into a salaried position), a move out of a salaried position into private practice, and, finally, expansion or contraction of the services a physician currently offers his patients. Each one of these phases requires careful consideration, information and advice from knowledgeable individuals in order for the physician to choose the best possible options available.

MSMS also recognizes that there will be continued cost pressures on the medical practice. The number one pressure on the overhead for physicians continues to be professional liability. Professional liability represents not only a risk from a professional standpoint, but also, an unpredictable cost. Your medical society addresses this particular issue at every opportunity and moves toward a solution which will permit physicians to practice medicine in Michigan without the constant threat of a disastrous professional liability outcome hanging over their heads.

Physician reimbursement systems will increasingly be a focus of MSMS activity. The total amount of money available to physicians in the state will not increase significantly in the decade of the 90s. For physicians to be successful, it will be necessary for them to run extremely efficient practices to reduce their overhead to a minimum. Competition for patients as well as limitations on the expansion of the types of services physicians can offer will necessitate increased practice efficiency and reduced practice overhead if physicians are to survive and succeed.

Electronic claims processing

MSMS is looking to the future and preparing itself to assist physicians in two major areas of office efficiency. First is the use of technology in your practice. Electronic claims processing is only the beginning. For those of us who have moved into electronic claims processing, the pressure will be increased to provide more information. For those physicians who have yet to incorporate this area into their practices it will become imperative that they do so in the very near future. A very informative article on electronic claims processing appears on page 17 of this issue. I encourage all physicians to study it carefully.

Personnel management

Another area MSMS will address is that of personnel management and staffing of medical practices. Demographically, the decade of the 90s will be one in which there will be more jobs than people to fill them. While the health care industry should remain attractive so far as careers are concerned, increasingly, as medical practices become more complex, physicians will have to staff their practice with individuals who are highly trained and who understand how to assist the physician in efficiently running the practice. MSMS is helping physicians to train staff, particularly in the area of billing and coding, through a series of seminars. Physicians will have to have comparative information about salaries, benefits, and educational opportunities for their employees. The heart of an efficient medical practice will be a well-trained staff that feels adequately rewarded. MSMS stands ready to assist physicians in this area. An article on this topic appears on page 22.

Your commitment as an active manager will be crucial to the success of your practice in the 90s. You will need to be open to numerous sources of information in order to evaluate opportunities and select the appropriate options for your practice. Successful physicians of the 90s and beyond will become more and more involved in all aspects of practice management. ■

Doctor Baumann serves as MSMS treasurer and president of Physician Service Group, Inc., an MSMS subsidiary.

Electronic Claims Processing

Deciding how you computerize is critical.

By Randall W. Braaksma

Last January, the Health Care Financing Administration (HCFA) faced a funding shortfall when Congress didn't appropriate as much money as anticipated. HCFA responded by instructing insurance carriers under contract to HCFA in each state to process all electronic Medicare claims as usual but to hold all paper Medicare claims. Luckily, about two weeks later, Congress appropriated additional funds and HCFA retracted the unusual instructions.

That emergency has passed, but the federal government's preference for receiving Medicare claims electronically hasn't. A proposal now in Congress would add a one dollar surcharge to every Medicare claim submitted on paper. HCFA says a paper claim costs about 50 cents more to process than an electronic claim, an amount that seems paltry until you multiply it times the billions of claims filed each year in the United States.

Private insurers are promoting electronic media claims too, because it also saves them money. When a paper claim comes into an insurer, its claims processing department must enter the information into the computer. The cost: about $11.50 per claim versus about $5 to process a claim submitted electronically.

It's obvious that the federal government and private insurers benefit from doctors submitting claims electronically, but are there benefits to doctors? Yes. Faster payments and fewer errors top the list.

Advantages to physicians

Electronic claims are more accurate than claims submitted on paper. Carriers estimate that about 30 percent of all paper claims have errors and require re-submission. That process can take anywhere from three to 10 weeks. Then there is still the time required to process the corrected claim.

Electronic claims processing reduces these errors. The operator inputting the data receives prompts on the computer screen. He or she must complete all necessary information or the software will prevent the claim from being transmitted. The old computer rule "garbage in, garbage out" applies, however. Doctors must communicate accurately to their staffs who handle billing regarding the procedures performed, and the staffers who handle billing must understand proper coding so that they input the correct information.

Because claims submitted electronically move through the system faster, you also receive your insurance receivables faster. The speed is not just a matter of electronics. Most insurers require practices to go through a formal qualification process which usually involves submitting sample claims. The carrier critiques these samples and, if necessary, recommends modifications to the physician's software. In effect, the insurance company explains in detail exactly what it expects...information that many doctors have never received before. As a result, the process runs smoother.

Also, electronic media claims software applies the same codes to identical procedures so payments are consistent. If you are coding your claims the same way every time and speaking to the carrier's computer in its language, the computer can only pay you one way.

Expert advice required

While there are advantages to submitting claims electronically, there are also pitfalls. Computer systems are complicated. Unless you're a "hacker," seeking expert advice is critical. A good place to start is with other physicians who have practices comparable to yours and who are using computer systems successfully. Judge for yourself, however, on the success of these systems. Human nature tends to emphasize the good points and gloss over the bad when people discuss business investments they have made.

Often, a discussion with a colleague will yield the name of a computer consultant who has helped someone make a successful transition from paper to electronic claims processing. A disinterested third party whom you trust can help you determine which system and how much computer power is right for your situation.

A consultant can also act as a buffer between you and aggressive computer system vendors. While there are many excellent vendors, they are trying, after all, to sell you a system, so take their recommendations with a grain of salt. Some vendors may exaggerate the financial advantages of electronic processing over paper by stressing that with a computer you'll have your insurance receivables two weeks earlier than with claims submitted on paper. This is true, but it's a one-time benefit. Once you've computerized you will simply adjust your financial management to a two-week cycle versus the previous four-week cycle.

In-house, batching, on-line

If your practice is small, if most of your patients pay at the time of service, of if your practice involves high-dollar, low-volume claims, electronic claims processing may not be for you. However, if you get more than three-fourths of your gross income from third parties, if you see a large number of elderly and indigent patients, or if you handle lots of claims...whatever their individual dollar value...the cash flow benefits of electronic claims processing could be substantial.

Once you've decided electronic claims processing makes sense for your practice, the next step is to determine what approach makes sense for your specific situation. There are essentially three avenues open to you: an in-house capability, batch processing at a service bureau, or an online connection to a clearinghouse.

In-house systems represent the greatest challenge. With this approach, the doctor buys or leases computer hardware and software and installs it on-site. Someone in the practice, perhaps the office manager, is responsible for inputting all data and transmitting it to the various in-

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Continued from page 17

surance companies. The challenge comes first in making the right choice for a system. There are about 200 different software systems currently on the market.

The second challenge involves keeping abreast of changes in each carrier's policies for submitting claims and keeping your software up-to-date. Without the ability to stay on top of these changes, you will simply create claims that get rejected. This approach does provide, however, the greatest amount of control over the process.

Batching is the other extreme. With this approach, the doctor contracts with an off-site service bureau to process claims electronically. The physician's staff physically takes the information for each claim which they have written out in long hand to the service bureau, where its employees key the information into a computer and send the claim on to the insurance companies electronically. The advantage of turning the entire process over to professionals offsets the loss of control.

On-line real-time systems connected to a clearinghouse offer a middle course. Again, the doctor has the option to buy or lease...and in some cases rent...computer hardware that he or she installs on-site. Under this arrangement, however, there is no need to buy or lease software. The service fee paid to the clearinghouse includes a real-time computer hook-up, which means essentially that you use the clearinghouse's software to process your claims.

As personnel within your office key into the computer claims information it travels instantaneously via a special telephone line to the clearinghouse's computer. From there, the clearinghouse edits the claims as necessary, sorts them, and sends them on to the appropriate carriers.

On-line, real-time systems have advantages over another way of working with a clearinghouse. Some doctors prefer a freestanding computer system in their offices into which their personnel enter claims information. Then, usually once a day, they transmit the information via a modem and regular telephone lines to the clearinghouse. This approach requires, however, buying or leasing software and the hassle of having someone make the telephone connection with the clearinghouse each day.

People and machines

Choosing to submit insurance claims electronically is a financial decision. A hard look at the numbers will give you the clearest picture of what's right for you to do. Once you make the decision to computerize, however, the emphasis shifts quickly from machines to people.

The first person you must consider is the vendor you deal with. To choose a reliable one, some experts suggest you begin by asking the insurance carriers you do most of your business with to provide a list of vendors they have approved to submit electronic claims. Compare the lists from each carrier to eliminate duplicates and narrow your options. Finally, ask the vendors still in the running to provide the names of physicians using their services to submit claims. You can check with these physicians to make sure the companies they are dealing with have a proven track record.

More important than your vendor is your office staff. Computers threaten many people. They find them difficult to operate and therefore intimidating. Some believe that introducing computers to the doctor's office will eventually eliminate their jobs. Helping your employees understand how the computer fits into your overall practice management is essential. Even then, you may encounter resistance. As in all personnel matters, communication is key.

A tool, not a cure

A computer billing system can provide a practice many things, but it cannot relieve a doctor of the responsibility for managing the practice's financial performance. Some physicians fall into the trap of believing that once their computer systems are up and running, they are doing all they need to do to manage the financial end of their practices.

In reality, choosing an employee to be responsible for processing and submitting electronic claims puts a great deal of control over the financial area of your practice in the hands of one person. You're much better off if you make that choice in terms of a career advancement for a highly-qualified employee.

Asking for volunteers, as some doctors have done, can have disastrous results. The youngest person with the least seniority usually ends up accepting the position simply because he or she is not afraid of the computer. Later, these doctors realize they have transferred by default control over a vital area of their practice to one of their least experienced, and perhaps least trusted, employees.

Computers will not solve other problems within a practice. Some doctors have mistakenly believed that installing a computer billing system will rejuvenate their practices. Rather than owning up to the real reasons the practice is floundering...deteriorating service, population shifts, increased competition...they seize upon the computer as the answer to their problems. Predictably, installing a computer billing system only adds to their problems.

Benefits beyond today

While computerizing does present problems, the benefits of submitting insurance claims electronically will outweigh them for many physicians. The advantages of computerizing become more apparent as you look beyond the benefits of electronic claims processing.

Many doctors, once they've seen how the computer streamlines their billing, discover how it can link them to the outside world. They are handling hospital and appointment scheduling with their computers. They are computerizing their medical records. While some worry about the security of medical records on computer, others argue that compared to a password-protected computer system, they are safer. Traditional hard-copy records are more accessible (and therefore easier to modify and copy) than computerized records, and they are subject to fire, flood, and theft.

In addition, some doctors are experimenting with patient-interactive systems. However, widespread use will probably not occur until older patients, intimidated by computers, pass from the scene and younger patients who have grown up with computers and video games constitute the larger share of the patient population.

Another benefit of computer use may soon have direct bearing on electronic claims processing. The technology is under development that will allow carriers to transfer payments electronically directly into a doctor's account. Once these electronic remittances are a reality, the computer billing cycle will be complete.

Randall Braaksma is an East Lansing-based freelance writer.

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The Art of Connectivity

Bringing healthcare information to the physician's fingertips

By Art Randall

No other participant of our nation's healthcare delivery system has accepted emerging technologies faster, or with greater enthusiasm, than our nation's physicians. Yet, most of these systems, such as CT and MRI scanners, for example, have been almost exclusively related to the treatment and direct care of the patient.

Today's US healthcare delivery system is complex, perhaps more so than any other system in the world. Yet most information required for interchange is gathered and distributed manually.

Consider for a moment the mountains of data that flow through the healthcare delivery and payment system every day. It has been estimated that more than 40 billion documents are created each and every year, and most of these documents consist of manually prepared, out-of-date, incorrect and duplicated information...largely inaccessible to and among those that created them, or to and among those with a need to know.

Each visit requires creation or confirmation of medical history, demographic, employer, payor and payment information. Each visit requires entries to a medical record. And for many illnesses, multiple visits to many providers may also occur. A single family physician visit may result in one or more specialty, outpatient and clinic visits for care and testing. Many visits may also result in one or more hospital stays. Each visit requires creation of medical record information and thus resulting in the provider creating their own records about the patient and the patient's illness.

As a result, in our highly mechanized society, we find that when it comes to healthcare, most, if not all, of the information regarding a patient is manually prepared, stored, and when needed, manually retrieved...a process that has changed little over the past 50 years. Healthcare information interchange between and among providers today remains a vestige of the past...a communication process that relies primarily upon the written or oral word. It is costly, inaccurate, inefficient, ineffective, and unresponsive to the needs of today's healthcare world.

> "Healthcare information interchange between and among providers today remains a vestige of the past...a communication process that relies primarily upon the written or oral word. It is costly, inaccurate, inefficient, ineffective, and unresponsive to the needs of today's healthcare world."

Why then, does it not only exist, but seemingly flourishes?

Information access zones

Viewing this dilemma from the physicians standpoint, most find themselves in one or more of three information access "zones." The first is the *dark zone.* While a hospital may already have mechanized much of the information that is needed by a physician, it normally offers no effective means by which the information may be shared among physicians, other hospitals and/or other members of the healthcare delivery system.

Most of the hospitals that do offer some means of information access, provide far too little information, making the system of limited value. Further, very few of those institutions that offer physician access capabilities have joined together with other hospitals and physicians to develop a common dataset and access protocol that would allow universal accessibility by all physicians to and from all hospitals.

To resolve the "dark zone" problem there must exist a clearinghouse intermediary to which all providers may be linked to gain information access, to and from the clearinghouse system, to and from the systems of the providers.

The second is a *dependency zone* that requires physicians to rely upon others to develop the necessary technology to remove them from the dark zone. For many it's a "chicken or the egg" problem. Physicians and hospitals both need to develop a method to exchange information, and both must have the technology in place to permit it. Yet neither can develop it alone without the other party's participation. Spending money to develop a system that no one will or can use is worse than having no system at all.

To resolve the dependency zone problem there must exist an intermediary that can provide the necessary interchange systems, interfaces, standards and protocols that will allow quick, easy, and economical access for all parties concerned.

The third is the *technology zone.* Not all physician offices, clinics, and hospitals are equal in their internal systems capabilities. While most medium and large hospitals have an order communication system installed, not all have a full and comprehensive patient care system installed. Few, for example, have a medical records imaging system, and fewer still have a teleradiology system; two systems that can provide a quantum leap in increasing the productivity and quality of care that would accrue for both the physician and the hospital.

To resolve the technology zone problem, there must exist an information clearinghouse to which multiple levels of information plateaus could be made available to the physician, depending upon the degree of provider automation available. But of equal, if not more, importance there must also exist an additional third party that has the proven ability to bring to the healthcare community advanced technology and information interchange "know-how" that would not only be of value to the hospital in its own right, but also of significant value to all participants of the healthcare community.

Such a third party consulting firm must be able to work with all of the providers in a community to develop a single, technologically functional information exchange and access plan for each of the providers in that community.

Continued on next page

Continued from page 21

A look at other industries

The same set of challenges has existed in other industries. Most responded to and successfully resolved essentially the same information gathering, storage and access problems that exist today in healthcare.

Take for example, the credit reporting industry. Today, information required to build credit histories comes from a wide variety of sources, including retail stores, banks, mortgage companies, credit card issuers, other credit agencies etc., each contributing to the central database. When information is needed by any subscribing member, the member simply accesses the agency's information system, receiving a full and complete report immediately.

Consider also how difficult it was to make a confirmed travel itinerary, just 30 years ago. Each of the foregoing described "zones" existed within the travel industry. Airlines and hotels competed with each other. The large airlines, hotels and car rental agencies that had reservation systems installed, felt that they had a competitive advantage over those that didn't. Today, all airlines and all major hotels and rental car agencies have now joined together for the common good, to give the traveller the highest level of quality service that is technologically and economically feasible.

A national network

The key to the success of such information flow and access is simple. First there must be a national network through which the many participants of the healthcare delivery system may contribute to and access a healthcare information database. Second, there must be central processing, storage and retrieval capability to update, maintain, process and allow access to the healthcare database developed. Third, there must be a standard developed for system connectivity, whereby each participant's system may be automatically connected with the national healthcare information database provided by the clearinghouse. And fourth, there must be participants.

Several corporations throughout the United States have the technology to develop a system that would provide physicians with remote on-line, immediate access to:

- Hospital Admitting and Registration Systems
- Patient Orders
- Patient Financial and Medical Histories
- Patient Test Results
- Nursing Progress Notes and Charts
- Hospital Medical Records
- Hospital and Clinic Scheduling Systems
- Hospital and Clinic Resource Management Systems
- National Health Information "Data-Banks"
- Payor Eligibility and Payment Status Information
- Editing/Submission and Follow-up of Healthcare Claims
- Employer Eligibility and Demographic Information
- Other Uses

The benefits are substantial, including lower healthcare delivery costs coupled with an increase in the level of the quality of the patient care provided. Yet, the value of increased productivity may be the most important contribution. Physicians will be able to respond faster to patient needs, by having more of the necessary decisional information at their fingertips.

The technology to develop a national information clearing and interchange network is available today...and the economic and care benefits are substantial. Only lack of the will to implement it stands in the way. ■

Art Randall is president of Art Randall & Associates, a Healthcare Marketing Consulting Firm based in St. Louis, Missouri. Randall wrote this article for Wellmark Incorporated, Westlake Village, California — a company which, through an alliance with AT&T, has developed a national private-channel communications system.

THE BUSINESS OF MEDICINE

The Personnel Crisis is Here

If it has not hit you yet, it will. Here's what you can do about it.

By George S. Conomikes

The greatest wave of new employees since the early 1900s hit the job market from 1970 to 1990. Two forces lent themselves to the "Buyer's Market":

1. The wave of baby-boomers. These were the young people born from 1945 to 1965. Times were good. Many families could afford, and had, two or more children. As these children completed their schooling a tremendous pool of talent was available for employers during the 1970 – 1990 era.

2. The wave of housewives and homemakers migrating to the ranks of full-time workers. In 1970, roughly 35 percent of married women were full-time employees. By 1990, approximately 65 to 70 percent were working fulltime. The number of "housewives" shrank significantly.

Because of these demographic changes, employers, with few exceptions, were not faced with significant recruiting problems and the cost of labor matched, neck-and-neck, the cost of living.

In the 1980s, there was a setback to the mentality of almost-automatic pay increases being pushed by strike threats in the unionized industries. This setback was President Reagan's firing of the striking air-traffic controllers. Virtually unprecedented, and unanticipated, it led to a de-escalation of union demands and to wage-income moderation that lasted throughout the 1980s.

Welcome to the 1990s

Starting in this decade, demographic factors are leading to a radical change in the employment market. Personnel shortages will be our next challenge.

1. The Baby Busters. Starting in 1965, birth rates in the United States dropped significantly and continued lower for the next 20 years. In the 1970s, schools experienced lower enrollments in the primary and secondary levels. High schools started to feel the drops in the 1980s.

2. The return of housewives to the labor market has slowed. They are, for the most part, already back in the labor force — you can't get much more than 70 percent of them out of the home. So this great labor wave has flattened.

Some depressing statistics

1. Demand for healthcare jobs is increasing. All jobs are going to be in demand and the supply, in most cases, simply will not be there to moderate escalating salaries. (see Exhibit I)

EXHIBIT I

Projected Growth Rate For Health Care Jobs

Medical Assistants	70%
Radiological Techs	66%
Physical Therapists	57%
Registered Nurses	39%
Licensed Practical Nurses	37%

2. The number of 18-29 year olds entering the workforce is 10 percent less in 1990 than was the case in 1980. This is the age group which is categorized as the "entry-level" employee — essentially a new entrant into the workforce.

And it's going to get worse, just four years hence.

3. In 1995, the number of 18 - 29 year olds is going to be another five percent less than in 1990, or 15 percent less than we experienced in 1980.

4. We have no accurate data on the numbers and percentages of "extra" housewives (the work force returnees) but we know the "wave" has leveled.

5. Women workers, the backbone of the medical office, have many more options for work than in the 1970s and 1980s: banking, law and medical school, are now valid options. In the "old days" women workers looked to teaching and nursing as major professional alternatives. Teaching and nursing are dying on the vine due to many other good paying options.

6. Turnover. A key job in all medical offices is that of receptionist. The job is tough and stress related. It usually is low paid. Result: according to the Health Care Group, turnover at this position is now 36 percent!! (see Exhibit II).

EXHIBIT II
High Turnover

(% of respondents noting high turnover for these positions; "high turnover" being defined by respondents)

Receptionist	36.8%
Medical Assistant	10.0%
Clerical/Insurance	8.7%
Registered Nurse	8.1%
Medical Secretary/ Transcriptionist	7.6%
File Clerk	4.6%
Multi Purpose Worker	3.2%
Licensed Practical Nurse	2.2%
Office Manager	1.5%

Getting out of the mess

We cannot solve your personnel shortage problems. They won't go away. However, we can address them and reduce their impact on your practice.

Some suggestions:

1. *Be prepared to pay better salaries.* As the labor pool shrinks it is going to happen. You may do well to consider going one step further.

2. *Pay above-average salaries.* Usually (not always) above-average salaries attract above-average employees. Above-average employees have the following abilities:

a. They are more *productive* because they are smarter, more energetic and have more skills.

b. You can hire experienced people rather than individuals with less experience. You will have lower *training costs* than if you hire less experienced employees. Training of less experienced and inexperienced personnel is costly and is stressful to co-workers as well as to management.

c. *Fewer errors.* Errors are costly and may result in costs exceeding the differential between an "average" and a "good" salary (See Exhibit III).

d. *Less turnover.* Low and average salaried personnel are always "looking" for another better paying opportunity. Well paid people have fewer options and more inertia.

e. Five well paid employees may be just as productive as six or five and one-half average pay employees. In other words, total salary costs may not be increased by the "better pay" strategy.

3. *Job sharing.* A number of practices finding full-timers hard to get are hiring two people to do the one job. Two RNs sharing the job; two billers/bookkeepers sharing the job. Benefits... You always have an employee (full timers take vacation days, sick days, and personal leave days). With job sharing you have them there when you want them. With part-timers you may also save by not paying for benefits such as health insurance plans, pension plans and profit sharing contributions.

EXHIBIT III
You May Get More If You Pay More

How a higher salary employee "made money" for one practice.

An orthopaedic client in the Midwest used a Radiologic Tech to assist in the back-office as well as take X-rays. This tech's salary was higher than the going rates for registered nurses and significantly higher than the pay level for a non-licensed medical assistant. The physician's rationale for the higher salaried tech? This person saves us time and money by...taking good X-rays, accurate studies, incurs minimal X-ray film waste, is excellent at cast application and removal and has good verbal communication skills. In other words, this high salaried "tech" is able to do more than an RN and much more than a medical assistant.

Creative work hours

Does your biller/bookkeeper have to work 9:00 a.m. - 5:00 p.m.? What if you allowed the person to work on a schedule convenient to her/his needs? You may also determine the job does not require 40 hours of work every week. Maybe when the physician(s) is away this individual can work fewer hours. Here you may have possible personnel cost savings.

Alternative time-off benefits

All current research on personnel indicates that workers — especially women employees — are willing to trade money for time off. If you are committed to a less-than-high pay scenario consider these time-off options.

1. *More vacation time.* One Texas practice provides "average" salaries but "above average" vacations...three weeks vacation for first year employees; four weeks for

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Continued from page 23

employees with two to five years of seniority; five weeks off starting the sixth year. They have no trouble finding personnel.

2. *Extra time bonuses.* Many practices allow personnel an extra half day off every month, in addition to regular vacation. One practice closes at noon every Friday. On top of their regular vacations these people are getting the equivalent of 25 extra days off.

3. *Bonus days off during "slow" seasons.* Ophthalmology practices are less busy December 15 - February 15. Maybe even offer some "extra" days off, especially during the Holiday season. ENT and Allergy practices are slower during non-allergy and flu seasons.

Recruiting and selecting

Spend more time at it. Interview more candidates. The more you interview the luckier you may get. Be more selective. Definitely only hire those whose references you are able to check.

Keep in mind this new "in demand" work force is going to be more demanding of supervision and management. They are going to want feedback about their performance to be constant rather than periodic. Whereas the baby boomers disdained performance evaluations, this new generation actually craves grades, performance evaluations and job reviews. They want a quantification of their achievements. It should be remembered that these were the children who prepared diligently for college aptitude exams and learned how to master Rubik's Cube and Space Invaders. As contrasted with the "Yuppie generation" of the 1980s, they are consummate game players, great grubbers, and they prefer short term tasks with observable results.

Training and cross-training

This is the weakest link in most practices. Disney spends four days to train young employees in product knowledge and personal improvement skills. That is a big investment. But it works and you witness it every time you visit Disneyland and Disney World.

No job "belongs" to one person. All jobs should have one or two other employees cross-trained to do the job when an individual is on vacation, personal leave or sick leave. They also can help the employee who needs help, take care of backlog of paperwork, over-booked and overworked back office and answer calls for back-up help.

Good place to work

Disney is a "good place to work." They pay low wages but they train. They make fun out of work. Consider...frequent meetings; frequent bonus-type awards (cash, time off, gifts) as recognition.

Bosses and managers should thank their employees *every day* for the pleasure of working with them. ■

George S. Conomikes is considered a leading authority on practice management. He is editor and publisher of Conomikes Reports, Los Angeles, California.

THE BUSINESS OF MEDICINE

Coping with physician payment reform

By James M. McKay

In order for practice incomes to remain strong, physicians are probably going to have to change the way they do business. Clinical decision making, once protected by statute from government interference, is now directly challenged by Medicare reimbursement policy. Limiting Part B expenditures and influencing certain aspects of the clinical practice of medicine are the intended outcomes of Physician Payment Reform (PPR).

With the Tax, Equity and Fiscal Responsibility Act (TEFRA) of 1982, a policy was established to restrict reimbursement for most physicians, including teaching physicians and hospital-based physicians, to the level of office-based practitioners. Medicare determined it had been paying hospitals for certain overhead costs required to be absorbed by office-based physicians in addition to the overhead included in the fee calculation for office-based practitioners. This regulation effectively eliminated a major revenue source provided by hospitals to their physician employees which forced many physicians to directly bill patients under Part B Medicare on a fee-for-service arrangement.

In 1983, Congress implemented a Medicare prospective payment system for hospitals based on diagnostic-related groups (DRG). Combined with strong utilization review controls, DRGs forced hospitals to promote outpatient services in an effort to diversify and to create alternative revenue streams. Technological innovations made it possible to render increasingly varied services on an outpatient basis. Consequently, the physician component paid under Part B Medicare grew from 22 percent to 28 percent of total Medicare expenditures between 1980 and 1988.

The various budget reconciliation acts of the mid-1980's began to deal with these trends. Congress gradually moved toward fee schedule approaches because of their ability to address inequities while controlling cost. Studies continued to be called for testing different scenarios with attention to utilization, specialty and geographic variables and specific procedures deemed to be overpriced. At the same time, in an effort to control physician behavior, there were significant policy disincentives to encourage a greater percentage of physicians to accept assignment.

After years of debate, physician payment reform was legislated by Congress under the Omnibus Reconciliation Act of 1989 (OBRA 89). The package of reforms replaces Medicare's existing reasonable charge method for physician payments with a resource-based relative value scale (RBRVS). The RBRVS will redistribute Medicare physician payments by assigning values for services that are based on the time, intensity and practice cost in providing each service. Currently, Medicare payments for many physicians are based on

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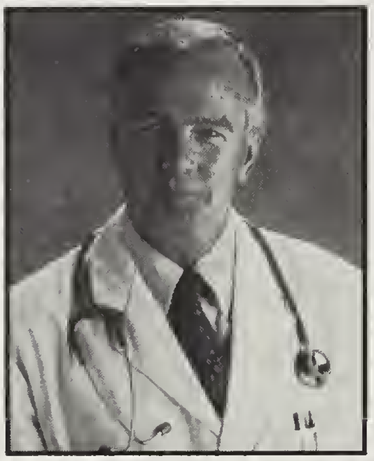

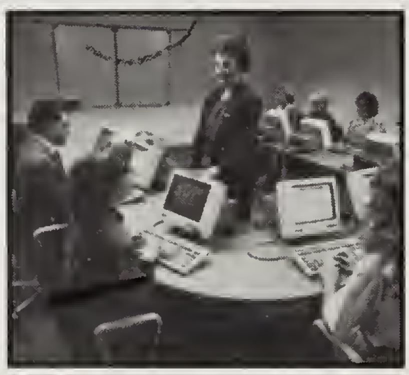

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Continued from page 25

what most similar providers in comparable locales charge for performing the same service.

The RBRVS, scheduled to be implemented over a four-year period beginning in fiscal year 1992, will be blended with prevailing charges to soften the immediate impact on physician incomes. The fee schedule is designed to accomplish budget neutrality while increasing primary care payments and reducing payments to specialists, particularly surgeons and traditional hospital-based physicians.

Annual increases in Part B Medicare payments are likely to be contained by a combination of the following measures:

- Initiating use of Volume Performance Standards;
- Reducing balanced-billing through the "limiting charge" rules;
- Tightening coding and other reporting requirements;
- Restricting annual fee schedule updates for services below the full inflation factor; and,
- Withholding a predetermined percentage of physicians' payment until the end of the fiscal year, at which time Health Care Financing Administration (HCFA) would determine the proportion of funds to release based on a comparison of actual and budgeted expenditures.

> But if other insurers follow suit, the financial impact of the Medicare fee schedule may be considerably more threatening.

Although the ultimate impact of Physician Payment Reform is unknown, some fundamental changes will have to be made by physicians to brighten their economic future. According to the Congressional Budget Office, a fully implemented plan, such as that planned for 1996, would cut physician payments for Part B Medicare an estimated 12 percent. But if other insurers follow suit, the financial impact of the Medicare fee schedule may be considerably more threatening.

Private insurers fear that physicians will attempt to recoup from them any losses caused by the new Medicare fee schedule. Many commercial insurers have already contacted Medicare to learn more about its approach and how they might apply it. Commercial carriers are studying the pros and cons of establishing their own resource-based fee schedules. Additionally, they are investigating how to tighten controls on volume and utilization along with limiting balanced billing to privately insured patients.

Business planning a must

These factors point to the necessity of each practice developing a business plan for coping with physician payment reform that includes managing reimbursements from their various revenue sources. Ensuring optimal reimbursement levels will necessitate detailed expertise in coding systems used by third party payors, in-depth knowledge of state and federal regulations and a solid understanding of payment policies and trends.

Since the standard game of comparing fees to the "customary charge" screen and staying one step ahead is no longer valid, some potential long-term strategies for limiting the negative impact of physician payment reform are:

• **Evaluate the financial impact of physician payment reform.** Physicians should begin to evaluate the specific effects of the RBRVS fee schedule implementation on their practice, taking into account their specialty, the size of their Medicare practice and the frequency of procedures most commonly performed. Other factors being equal, a charge structure generally higher than the geographic area could pose a greater detrimental impact under the fee schedule than a generally lower charge structure.

While it may be too soon to determine the ultimate impact over the four-year phase-in period, it is not too soon for physicians to determine their unit cost for providing each service. Unit cost analysis will enable physicians to make scientific pricing decisions based on net collections and profit margins, as well as prevailing charges in their geographic locale.

• **Obtain reimbursement management expertise.** As carriers tighten their payment policies and the number of denied or underpaid claims increases due to improper coding and reporting requirements, physicians should develop plans to enhance their knowledge of coding and reimbursement management. Proper use of Current Procedural Terminology (CPT) coding may partially offset reductions in the Medicare fee schedule. Context (Burr Ridge, IL), one firm providing coding systems and software to the healthcare industry, estimates that between $10 billion and $20 billion in potential physician fees are lost due to improper coding practices.

Pre-editing for proper coding and individual insurance reporting requirements will increase the probability that physician claims are appropriately paid. Since 1990, many Medicare carriers have begun utilizing specifically designed software to detect coding errors on claims. Such errors include: invalid procedure and diagnostic codes; invalid code linkages; missing supporting documentation; and, "unbundling" of packaged services.

Due to the administrative burden and operational cost, pending claims often are not followed up effectively. The American Medical Association (AMA) estimates that insurance companies save between $11 billion and $13 billion per year on nonpayment of pending claims. Therefore, it is important for physicians to obtain reimbursement management expertise for their practice.

In addition, third party payers increasingly rely on coding audits as a method of enforcing cost containment measures. Pre-editing for proper coding and billing requirement lessens the likelihood of unintentional audit liability from reporting errors.

• **Submit electronic claims.** Because of its potential to immediately enhance cash flow due to shorter turnaround time and tighter control of claims, improving technology to provide greater use of electronic claims submission should be a top priority.

Longer turnaround times are an unstated but intentional policy disincentive against those providers who do not use electronic means to submit claims. Because electronic claims are usually processed without manual intervention, personnel reductions in any carrier's claims adjudication department would not have a serious impact on electronically processed claims.

A recent study by Frost and Sullivan stated that the administrative cost of processing a paper claim is $3.60 compared to $1.50 for electronic claims. Since electronic claims are less expensive to process, Medicare and private insurers will continue to focus on this technology as a measure of cost containment. There-

Continued on next page

Continued from previous page

fore, physicians should begin making every effort to submit claims electronically to avoid a substantial build up of their accounts receivable.

- **Increase patient volume and quality of payor mix.** Enhancing the proportion of better paying patients to offset reductions in Medicare volumes is a difficult objective to achieve, particularity if managed care programs such as HMO/PPO'S have a strong presence and have captured a representative market share.

> Focused marketing efforts including direct mail, service offerings tailored to women and working adults, convenient hours of operation and coordinated appointment scheduling to reduce patient wait-time.

Primary care physicians can attract an increasing number of private pay patients through focused marketing efforts including direct mail, service offerings tailored to women and working adults, convenient hours of operation and coordinated appointment scheduling to reduce patient wait-time.

Subspecialists and hospital-based physicians can also facilitate practice growth and attract a larger number of privately insured patients by carefully cultivating relationships with their referring physicians. Some of the more important decisions used by physicians in determining their referral patterns are:

- Professional acquaintance with the referral specialist;
- Simplified access to the specialist or referral center;
- Ease of patient scheduling;
- Prompt communication about the medical status of referred patients;
- Assured return of referred patients to the referring physician's practice;
- Moderate cost of service;
- Perceived quality of care.

All factors being equal, perceived quality of care will attract the optimal quality patient mix in each particular geographic market. ■

The author is a practice management consultant.

Dear Carl,

Congratulations on your new medical staff leadership position! Now you're not only a physician – you need to be a manager, negotiator, arbitrator, and even a parliamentarian. I wish I had received some special training when I first took a position like yours!

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Office Risk Analysis

By Greg Brusstar

The scope of risk management goes beyond patient care. It also involves addressing liability risks associated with your business operation.

To reduce "administrative" risks, physicians should address non-clinical issues such as patient satisfaction, record keeping, tidy surroundings, and courteous billing practices.

Risk managers at Michigan Physicians Mutual Liability Company (MPMLC), the MSMS-created and endorsed professional liability carrier, say these business issues are important.

"It's important to eliminate the business-related risks because they often become the focus for lawsuits," said Kathleen Dropp, an MPMLC Senior Risk Management Consultant.

MPMLC offers two services that emphasize the reduction of administrative risks: the Office Risk Analysis and the Patient Information System Analysis.

Office Risk Analysis

1) **An office overview.** The risk manager begins an Office Risk Analysis (ORA) with a walk-through survey of the premises. "When I walk through, I let the office staff do all the talking," said Ms. Dropp. "It increases the staff's comfort level so they feel they can be open and candid during the interview process.

"We always emphasize that the ORA should be a positive experience...an opportunity to reduce liability risks and prevent a lawsuit." MPMLC policyholders also can qualify for a premium reduction if certain criteria are met or if they agree to comply with recommendations offered.

Here are some of the things the risk manager is looking for:

- **Physical environment.** Does any object in the office hallways pose a physical hazard? Are the reception areas and treatment rooms clean and well-lighted? Are fire extinguishers available? Are fire exits marked? Does the staff have a plan in case of an emergency?
- **Staff activities.** Are staff tending to their duties and observing patient confidentiality protocols? The risk manager uses informal cues to get a reading on employee morale. Poor staff morale influences care provided and thus patient satisfaction with the physician and practice.
- **Equipment condition.** Is equipment clean and calibrated? Are preventive maintenance schedules and repair records kept and adhered to?
- **Laboratory.** Are Centers for Disease Control (CDC) regulations followed? Cleanliness of the area and sterilizing systems used are checked.
- **Medication samples.** Are expired medications regularly purged from the supply? Is the supply locked in a cabinet?
- **Reception area.** How long do patients generally wait? Reduced patient waiting time is linked to higher patient satisfaction. Are magazines, a TV, or a VCR available to entertain waiting patients?
- **Examination rooms.** Are supplies, reagents, and instruments readily available?

2) **Interviews with key staff.** After the initial walk-through, the risk manager interviews key staff members and the physician. Areas for evaluation include billing practices, patient reception and scheduling, medical records keeping, informed consent procedures, management issues, and patient feedback.

3) **Billing procedures.** Questions asked include: "How are patients notified of late or delinquent payments?" "Does the physician have a periodic payment plan for patients?"

If a decision is made to report the patient to a collection agency, make sure you give proper advance notice. If you do not, it's a sure-fire way to anger a patient.

4) **Patient reception and scheduling.** "Physicians are learning the value of a receptionist who can skillfully, politely, and promptly greet and schedule patients," Ms. Dropp said. Indeed, receptionists need to be excellent communicators, friendly at all times, knowledgeable about the practice, and able to adeptly handle anxious patients. "A rude receptionist can turn patients off and may cause a patient to leave a physician's practice," Ms. Dropp said.

A pleasant waiting room ambiance is helpful for increasing patient satisfaction. "One physician's waiting room had sugar-free cookies and herbal tea, which patients really seemed to enjoy," Ms. Dropp said. "Another had a VCR with a video library. Sometimes these extras can make patient waiting time seem shorter."

5) **Medical record keeping.** Important areas for review are the patient follow-up system, signature legibility, prescribing practices, completeness of histories and physicals, and availability of medication flow sheets. "The medical record is a legal document and is a critical component of quality of care," Ms. Dropp emphasized.

Physicians are urged to avoid releasing original documents. "When a record is requested, a copy with a signed affidavit that the record is authentic and complete will almost always be sufficient," Ms. Dropp said. Of course, the copy should never be made or released without the patient's written approval.

6) **Informed consent.** Informed consent can be confirmed with either progress notes or a pre-printed consent form. Risk managers recommend both. "Double documentation is a good habit to get into," Ms. Dropp said. "The informed consent should be reflected in progress notes as well as on a consent form. This provides a more defensible position."

In some cases, physicians hesitate to use forms because they may offend or alarm patients. To deal with this, physicians should emphasize the educational aspect of the informed consent process and document the conversation in a detailed progress note.

7) **Management issues.** In discussions with the physician, staff management techniques are addressed, along with use of written annual evaluations.

Regular staff meetings are encouraged to discuss problems and concerns. Physicians should be open to appropriate staff input on office matters. "The staff should be valued for its ability to keep the physician on his toes," Ms. Dropp said.

Ms. Dropp cited three examples of excellent physician management. One physician, who owned several physician office buildings, enlisted his office staff to help manage the properties. Each of the staff members were rewarded by receiving a percentage of profits from the buildings.

Continued on page 31

Closed Claim Review Sessions

Sponsored by

Michigan State Medical Society
and
Michigan Physicians Mutual Liability Company

Examination of closed medical malpractice claims is an effective method for providing risk management education. Closed Claim Review Sessions are round-table discussions of two actual closed Michigan malpractice cases. They are specialty-specific and structured to encourage group participation, allowing participants the opportunity to explore issues surrounding the cases and possible preventive measures that may be incorporated into their practices. Following the discussion, the outcome of each case, extenuating factors affecting defense of the case and pertinent risk management issues are addressed by risk management representatives from MSMS and MPMLC.

To assist you in obtaining addtional merit rating credits and to enhance your risk management knowledge, MSMS and MPMLC are co-sponsoring Closed Claim Review Sessions in various locations throughout the state. The sessions will focus on three clinical areas: Obstetrics/Gynecology, Medicine, and Surgery. Participants should register for the particular program which most closely applies to their area of practice.

Program Benefits

For participation in this 60 to 90 minute session, physicians will receive 3.0 Category I CME credits. Physicians insured with Michigan Physicians Mutual Liability Company (MPMLC) will receive a 2 percent premium reduction. Physicians insured with Physicians Insurance Company of Michigan (PICOM) are eligible for a 2.5 percent reduction.

Registration

Case summaries and pertinent medical records will be supplied to each registrant in advance of the program. Therefore, to allow adequate time to mail the materials to you, ***please register at least one week prior to the program you wish to attend.*** Registration will be limited to twenty participants per program. The cost of the program is $40. To register, please return the attached form with registration fee to: **Closed Claim Review Seminars, Office of Physician Education, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48826-0950, or register by calling (517) 337-1351.**

Program Dates and Locations

All programs begin at 8:30 a.m. and end between 9:30 and 10 a.m.

A continental breakfast will be served.

Obstetrics/Gynecology	
June 17, 1991	**Traverse City**/*Holiday Inn*
June 18, 1991	**Saginaw**/*Best Western*
June 19, 1991	**Grand Rapids**/*Grand Rapids Regional Center*
June 20, 1991	**Troy**/*Hilton Hotel (not the Northfield Hilton)*
June 25, 1991	**Ann Arbor**/*Weber Inn*
June 26, 1991	**Detroit**/*Wayne County Medical Society*
July 16, 1991	**East Lansing**/*Michigan State Medical Society*
Surgery	
July 10, 1991	**Bay City**/*Bay Valley Resort*
July 15, 1991	**Traverse City**/*Holiday Inn*
July 17, 1991	**Troy**/*Hilton Hotel (not the Northfield Hilton)*
July 18, 1991	**East Lansing**/*Michigan State Medical Society*
July 23, 1991	**Ann Arbor**/*Weber Inn*
July 25, 1991	**Grand Rapids**/*Grand Rapids Regional Center*
July 30, 1991	**Detroit**/*Wayne County Medical Society*
Medicine	
August 8, 1991	**Bay City**/*Bay Valley Resort*
August 13, 1991	**Troy**/*Hilton Hotel (not the Northfield Hilton)*
August 15, 1991	**East Lansing**/*Michigan State Medical Society*
August 19, 1991	**Traverse City**/*Holiday Inn*
August 21, 1991	**Grand Rapids**/*Grand Rapids Regional Center*
August 27, 1991	**Ann Arbor**/*Weber Inn*
August 29, 1991	**Detroit**/*Wayne County Medical Society*

Registration Form
MSMS/MPMLC Closed Claim Review Sessions

Name ____________________

Address ____________________

City ____________________ State ____________________ Zip ____________________

Phone (   ) ____________________

Seminar Date ____________________

☐ $40 Registration enclosed

☐ Bill VISA/MC Card number ____________________ Exp date ____________________

Signature ____________________

For more information, contact Julie Smith, Chief-Risk Management Development, MSMS (517) 337-1351

Continued from page 29

Another physician...for one week each year...closed his office and sent each of his staff members to a conference in another city. The physician paid all expenses...and provided spending money!

For another, a non-monetary incentive worked. The physician simply improved communication with the staff. He regularly updated them on the hospital procedures he was performing and other activities related to hospital committees. "It brought the staff up to another level of involvement in the physician's practice," Ms. Dropp said. "It was a real boost to their self-esteem, and provided them with valuable information."

8) **Patient feedback.** Risk managers emphasize the importance of conducting anonymous, periodic patient surveys. "If there's a problem in the practice or with a particular staff person, the patient survey will usually reveal it," Ms. Dropp said.

An ORA conducted by a risk management consultant is $975. An ORA conducted through a self-assessment survey is free to MPMLC insureds. MPMLC policyholders who participate (through on-site review or self-assessment) and agree to risk reduction recommendations will receive a four percent annual premium discount applied for three consecutive years.

Patient Information System Analysis

A Patient Information System Analysis is a review of all verbal, written, and audiovisual information provided to patients in a physician's practice.

"In addition to reducing liability risks, good patient information has been shown to contribute to positive patient outcomes," said Deborah Piazza, an MPMLC senior risk management consultant. "One 1989 study conducted by the International Patient Education Council showed hospital length of stay can be reduced by as much as half a day through better patient education. Good patient education is well worth the time and effort."

1) **Printed materials.** Is information current and pertinent? Does it cover a majority of procedures performed by the physician? Physicians are encouraged to develop a system for cataloging all printed materials furnished to patients. A sample of each information piece should remain in the file for reference, even when the materials have become outdated and have been replaced. In the event of a future lawsuit, a physician may have to provide proof that the materials were distributed during that time period.

2) **Distribution of materials.** Who distributes the materials? Are they distributed on a consistent basis? Is the name or description of the material noted in the medical record? Has the physician documented all significant information discussed with the patient?

Ms. Piazza recalled one case in which a failure to document distribution of information produced a lawsuit. The physician suggested an amniocentesis as an option to determine whether the patient's baby had Down's Syndrome. The patient decided against the amniocentesis because of risks explained by the physician. When the patient's baby was born with Down's Syndrome, the patient sued the physician for damages associated with overstating the risks. If she had received accurate information, she claimed, she would have opted for an amniocentesis, discovered the Down's Syndrome, and chose to have had an abortion. The physician claimed he provided accurate information about the procedure, but there was no supporting documentation in the medical record. "It was the physician's word against the patient's," Ms. Piazza said. "Often times, from a legal standpoint, if it's not written in the medical record, it didn't occur."

3) **Audiovisual aides.** Although not required, many physicians are using patient education programs on video cassette. A TV and a VCR for the office can be a good investment.

4) **Prescription drug information.** Written information should be provided about common prescriptions, high risk medications, and over-the-counter medications.

The Information Analysis is free for MPMLC insureds. Physicians conduct the review through self-assessment, or it is conducted by a consultant in conjunction with an on-site ORA. A two percent premium discount is granted to MPMLC insureds for an approved Patient Information System. ■

Information for this article was provided by Michigan Physicians Mutual Liability Company.

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Michigan Medical Group Managers Association

Providing better business for doctors

By Ralph Ward

The one-physician general practice is slowly entering the realm of medical folklore, and with it the days when doc had to (and indeed, was able to) to handle all the day's paperwork after the last appointment. It is hard to name a single change in medical practice over the past generation that has not made the administration and management of a medical practice more complex, more specialized, and more burdensome.

The role of the medical practice group manager has likewise evolved over time, growing in responsibility and professionalism. Group managers first appeared on the scene many years ago. According to James E. Long, administrator, Ballenger Medical Group, Flint, the concept of the group manager as a professional job description started out quite simply. "There was a long-accepted need for such a position. But 50, 60 years ago it was a fairly simple operation. The manager made sure the personnel were there, handled claims processing and other paperwork."

A national group, the Medical Group Managers Association (MGMA), formed in 1926 to meet the professional needs of this growing specialty. Today, the MGMA is America's largest professional group for administrators in ambulatory health care, with members representing almost half of the country's physicians in group practice. The association offers administrators information services, education programs, and legislative input. National members are overwhelmingly affiliated with free-standing clinics, and over 80 percent take part in MGMA-affiliated special interest groups on such topics as human resources and financial management.

A group of Michigan members, after attending an out-of-state MGMA meeting in 1973, joined to form their own state group, the Michigan Medical Group Management Association (MMGMA). MMGMA, which is affiliated with MSMS, has a current membership of 235. The concentration here is on state issues, including methods for dealing with Michigan's liability climate and reimbursement. The second objective is to offer group managers networking and mentoring opportunities outside their immediate areas, but on a more convenient scale than a national group allows.

Interaction important

Constructive interaction between group managers, and between managers and those in fields impacting health care, is important. The administrators must be aware of the latest topics facing medical practice, because their job is, literally, on the front line of the administrative issues challenging health care today. Of course, such issues as third-party payment shortfalls, paperwork burdens, and liability are burdens facing everyone in the profession. But the group manager is the one who must grapple with them daily, and wrest workable solutions if the business is to survive.

These fast-moving changes in the concept of "group management" have led to changes in the skills required of members. According to Long, "members today face greater responsibilities. They work with third party payers, and represent their groups in dealing with hospitals to make sure the groups' interests are represented."

The skills and training of managers have also increased to reflect these changes. The career tracks for early group managers were a hodge podge of nonspecific training. People with backgrounds in hospital business, accounting, even education, found their way into group practices, and essentially taught themselves the ropes.

Group practice management today, however, requires a specialized, expanding body of skills, so the MMGMA and its national affiliate place emphasis on ongoing training and development. A unit of MGMA, the American College of Medical Group Administrators (ACMGA) offers self improvement and career development programs. The ACMGA certification option allows members to gain credit for their ongoing skills development. Three levels of certification are available, the highest being a Fellow of the ACMGA. Members also gain access to a database of information on education, new management technology, publications, computer programs and demonstration projects. National and local member magazines and newsletters help round out the member administrator.

Leadership needed

What are the qualities needed for medical group managers in the 1990s? Increasingly, the administrator has to demonstrate leadership in operating a group practice. According to Warren White, business manager, Mid-Michigan Physicians, PC, Lansing, (and MMGMA president-elect), "We take the lead on the issues we're facing, from reimbursement, to Medicare, to the issue of health care rationing."

"(The group manager) is the person who essentially runs the group, especially in smaller practices," observes James Long. If group managers of the past were essentially reactive to the forces influencing health care, today they are likely to be personally involved in negotiation and policy setting, pushing the boundaries of medical practice management beyond their desks into the world at large.

The group manager may seem removed from the direct service of providing health care in their practices, but the human aspects of providing quality care, and of improving people's lives, is ever present for that person behind the desk. "This is an enjoyable occupation," muses Long. "We're in the health care delivery systen, helping patients. And if we can help run an efficient system, we can offer the patients cost containment." ■

Ralph Ward is a Lansing-based freelance writer.

DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS ISSUE 5 JULY 1991

Medical Inquirer

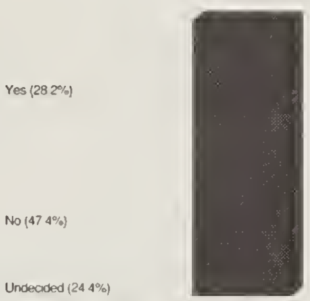
RESIDENT PHYSICIAN ATTITUDES TOWARD PRACTICING IN MICHIGAN 1991

Nearly one-half of resident physicians in Michigan intend to leave the state after completing their residency training. Of those who are leaving, more than two-thirds had not intended to stay prior to their residency. MSMS surveyed 2,200 of the approximately 4,400 resident physicians in Michigan, with 367 responding.

Residents Planning to Practice In Michigan

Less than a third of the residents surveyed actually planned to stay in Michigan, with another quarter undecided. Forty-seven percent of residents are not staying in Michigan when their training is completed.

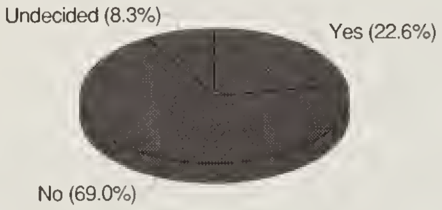
Planning to Practice in Michigan
1991 Resident Physician Survey



Percent of Residents Leaving Who Planned to Stay Prior to Residency

Twenty-two percent of residents who are leaving Michigan had originally intended to stay but changed their minds. Another eight percent had not decided prior to entering their residency program. More than two-thirds of residents never intended to stay in Michigan, with 80 percent of these citing malpractice as a deterrent to practicing in the state.

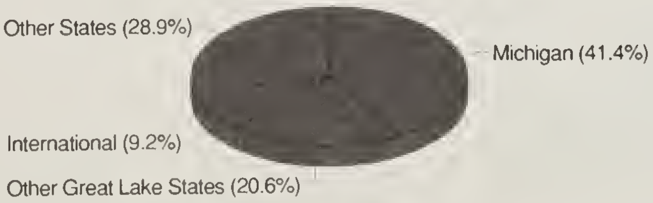
Planned to Stay Prior to Residency
1991 Resident Physician Survey



Medical School Location

Forty-one percent of residents that responded to the survey were graduated from Michigan medical schools. Twenty-one percent came from other Great Lakes states, and 29 percent came from other states. The remaining nine percent of residents were international medical graduates.

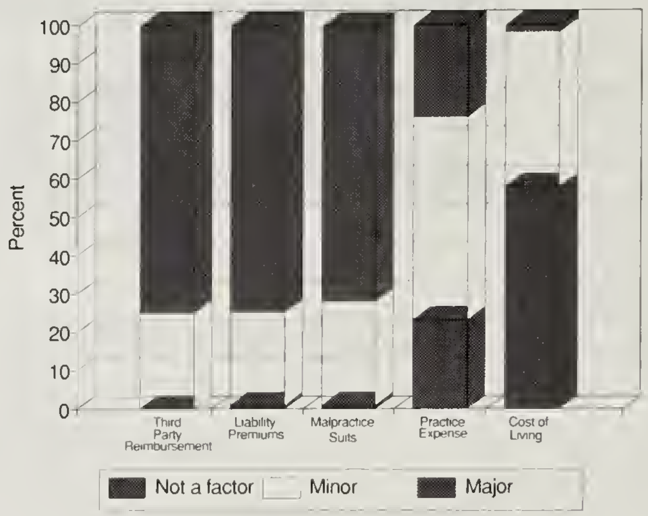
Medical School Location
1991 Resident Physician Survey



Problems Anticipated By Residents Who Are Staying In Michigan

Three-quarters of the residents who plan to practice in Michigan consider third party reimbursement and liability premiums to be the most significant problems they will face. The incidence of malpractice suits was cited by 72 percent.

Problems Anticipated by Residents Who Are Staying

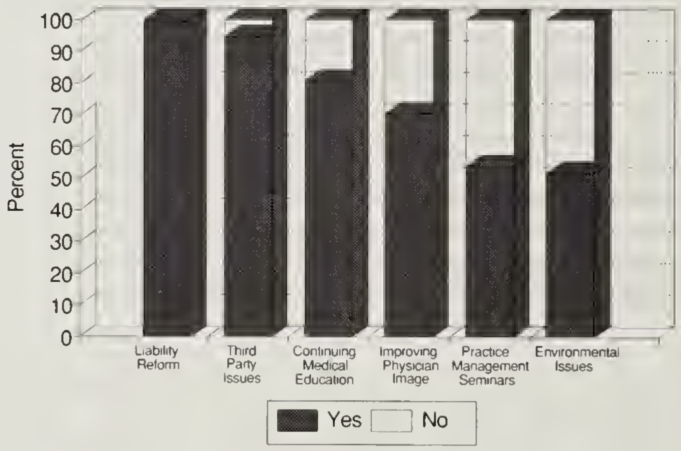


Priorities For Organized Medicine

Resident physicians overwhelmingly endorsed liability reform as a priority for organized medicine, with 99 percent of respondents saying it is an important activity. Third party issues followed close behind at 94 percent.

Priorities for Organized Medicine

1991 Resident Physician Survey

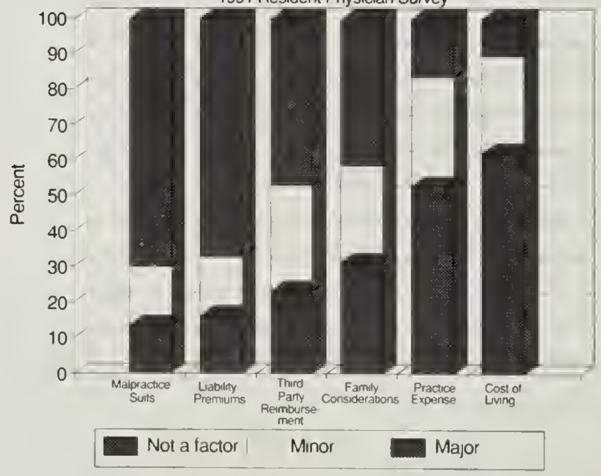


Factors Influencing Residents Leaving Michigan

The incidence of malpractice suits was cited by 70 percent of residents as the primary reason they are leaving Michigan. The cost of liability premiums followed close behind, at 67 percent. Third party reimbursement was a major reason for 47 percent of the residents who responded.

Factors Influencing Residents Leaving Michigan

1991 Resident Physician Survey



Medical Inquirer

DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS

A publication of the Michigan State Medical Society Department of Medical Economics and Health Care Delivery

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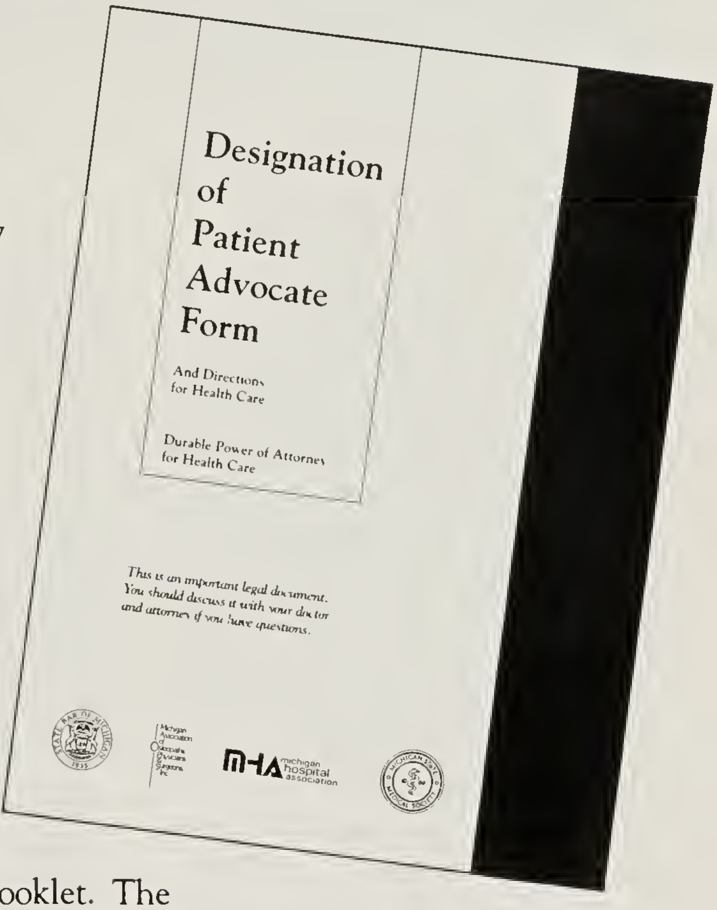
Durable Power of Attorney for Health Care Order Form



Designation of Patient Advocate Form

And Directions for Health Care

Durable Power of Attorney for Health Care

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MSMS urges individual physician offices to order the new Durable Power of Attorney for Health Care Designation Forms to distribute to patients as a public relations activity. The forms were developed and approved by MSMS, the State Bar of Michigan, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons.

The forms provide patients with the means to appoint a patient advocate to make health care decisions for them if they become incapacitated. Distribution of the document serves as a goodwill gesture that can demonstrate to patients how physicians are working to help them.

Designation Forms and accompanying brochures can be ordered through MSMS. Price is 40 cents for the pair when ordering 100 or more. Under 100, the price is 45 cents. Minimum order is 50.

The Designation Form is an eight page 8 1/2 by 11 booklet. The document is designed to be a "user friendly" form, particularly for older patients. The short patient brochure accompanying each form covers more detailed information about the new durable power of attorney law.

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INDOOR AIR POLLUTION
DANGERS OF THE GREAT INDOORS

By Ralph D. Ward

April 25, 1991. More than 1,500 employees at the 36th District Court in Detroit are evacuated when diesel fumes from an adjoining loading dock circulate through the building's ventilation system. Twenty-five are treated and released for dizziness and other symptoms at Detroit Receiving Hospital. The occurrence is the latest in a long series of complaints and incidents involving the building, including a pending court case against the property owners demanding renovation of the ventilation system.

In the public mind, the topic of indoor pollution consists of such incidents popping up in the news. Stories on "second hand cigarette smoke" deaths; the home radon gas scare of a few years ago; and the most famous event, the deaths of 29 hotel guests at an American Legion convention in 1976. News items on indoor pollution pop into the popular consciousness for a moment, but then fade in comparison to the wider, much greater long-term concern over our earth's environment and its effect on our health.

But, ecologically speaking, we may be overlooking the clearcut forest for the trees. Because indoor pollution is far more intense, more common, and presents greater hazards for health than almost any pollution hazard encountered out of doors. Health care professionals are much more likely to encounter symptoms caused by indoor pollution — but too few are alert to these causes.

Part of the problem facing physicians on indoor pollution issues is the variety of causes. Greater use of exotic chemical compounds in home and commercial construction over the past 40 eyars adds potpourri of possibly harmful elements to the air. Of even greater concern are building construction and retrofit practices of the last 15 years. Starting with the first energy crisis of 1973, there has been a near obsession with sealing every possible route of air leakage into structures to prevent air "infiltration." The massive commercial building boom of the 1980s, which nearly doubled the amount of office space in the US, used closed, tightly-sealed ventilation systems as standard practice.

There is nothing inherently unsafe about such "hermetically-sealed" buildings if the ventilation is well planned and well maintained. But this is not often the case. A 1986 National Institute of Occupational Safety and Health study of 356 office buildings found half of all employee respiratory and sensory discomfort complaints could be blamed on poor air-handling practices and design.

The problems have been classed under their own heading, "Sick Building Syndrome." SBS is gaining recognition as a health problem, though some authorities consider the term too facile and all inclusive. "SBS becomes an emotional issue when it's diagnosed," says Martin Charles, MD, a member of the MSMS Task Force on Environmental Health. "The symptoms are nonspecific, and could be caused by any number of things." Doctor Charles points out that an SBS diagnosis can cause a near-hysterical reaction among employees.

Much of the problem with blaming a "Sick Building Syndrome" and, indeed, the problem facing health care professionals treating such a malady, is the subtlety and enormous variety of contaminants causing reactions. Molds, pollens, fibers, chemicals and solvents, cigarette smoke, viruses, or a combination of these agents can cause symptoms from minor irritation to a serious Building Related Illness (BRI) such as the bacteria that caused Legionnaire's Disease.

Although all buildings are susceptible to environmental ills, modern offices are particularly prone, not only due to their tight windows, but because all ventilation depends upon the built-in HVAC system. Poor design can then cause major havoc. In the Detroit 36th District Court incident, a main outside air intake was located near a loading dock, allowing diesel fumes from an idling truck to contaminate the entire building.

HVAC maintenance is another Achilles heel. A recent article on SBS in Philip Morris magazine noted that modern buildings are designed to have a lifespan of approximately 75 years. The air handling systems, however, are only good for about 25. Dirty ducts and filters, allowing contaminants and humidity to pool, can turn the HVAC system into a giant Petri disk for microorganisms.

Although recent indoor air concerns have focused on offices, the traditional manufacturing and industry problems remain. Occupational safety has given years of study to the exposures of industrial workers, to contaminants, to the setting of safe air levels, and research on how to make factory air safer. "Occupational doctors were the first environmentalists," says Doctor Charles. But, although on firmer ground than office air study, keeping factory air safe remains complicated by the development of new, questionable compounds, evidence that exposures formerly thought safe may carry unseen risks, and gaps in enforcement.

The home is the final frontier for indoor air pollution, and air here can be as dangerous as on the job, if not more so. The 70's push for energy savings not only plugged the air leaks in many homes; it often brought its own source of indoor pollution. "Certain homes, especially mobile homes, were insulated with urea foam," says Doctor Charles, "and this is a strong source of formaldehyde." The practice has been stopped for some years, but the results of long term, low-level formaldehyde exposure remain uncertain.

But the home may offer far more toxic risk than contaminated air. Although the handling, storage, and disposal of toxic materials is strictly regulated in commerce, Michigan homes often are time bombs of poisonous or environmentally destructive materials — and face almost no regulation. Insecticides, household cleaners, petroleum distilates, paints and pesticides are some of the hazards to be found. Some are stored in old containers that may leak, seeping into the air or water systems, or coming into skin contact. While the tragedy of small children ingesting household poisons is too common, in such cases diagnosis is fairly straightforward. But what happens when the exposure is minute and long-term?

Such recondite diagnosis is often required for another household contaminant, lead. Blood levels as low as 10 micrograms per deciliter have been associated with adverse health effects in children. Lead has been a common companion for much of history, but is slowing being eliminated in paint, food storage and gasoline. Recent EPA requirements will require the contaminent of lead hazards in public water systems over the next decade. Practitioners should be aware of the more subtle hazards still present from old lead paint chips, private plumbing systems, and hobby or industrial contamination.

The home environment issue receiving the most recent publicity has been radon gas seeping into basements from the surrounding soil. A radon scare swept the country several years ago, but many experts fear that the real, long-term health threat posed by this carcinogen has been forgotten. Mark Upfall, MD, is a physician in the Division of Occupational & Environmental Medicine, Wayne State University School of Medicine, and a radon authority. "There is an association between radon and cancer, and many homes in Michigan have a problem. In Wayne, Oakland and Macomb counties, 20 percent of homes tested had basement radon levels above the EPA action level of four picocuries per liter." In Oakland County more than a quarter of homes had levels above this threshold.

Home air quality woes may exist on a smaller scale than in office buildings, but can often, proportionally, be worse, due to long-term neglect. Heat and sewage vents may be clogged; molds and moisture may accumulate for years in out-of-the-way places.

In one case, the residents of a home developed chronic allergy symptoms, which would not respond to symptomatic treatments. A long process of elimination found that moisture had accumulated in crawlspace insulation, nurturing molds that infiltrated the living area. A general cleanup and use of a humidifier solved the problem. In another case, a woman, living alone, developed lassitude, dizziness, and lost more than 40 pounds over the period of a year, and visits to several physicians failed to disclose her problem. The "doctor" who saved her life turned out to be a HVAC system repairman, who found that the heat exchanger in her gas heater had rusted away, allowing carbon monoxide to seep into her home.

Such examples show the difficulty physicians may have in pinpointing environmentally-caused symptoms. "Most (physicians) not involved in environmental medicine or toxicology don't pay enough attention to this," says Doctor Charles. "Physicians should start paying more attention to where patients work, where they live, their type of heat, and their specific allergies. Any physician should make it a point to check into lifestyle."

Ralph Ward is a Lansing-based freelance writer.

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MEDICAL WASTE ACT
REQUIRES PHYSICIAN COMPLIANCE

Editor's note: Following is an article written by Lawrence Chadzynki, RS, MPH, of the Michigan Department of Public Health. The article, which first appeared in Michigan Medicine in July 1990, provides a detailed explanation of Michigan's Medical Waste Regulatory Act of 1990. It is reprinted here as a reminder to physicians that they must comply with the new regulations set forth in this Act.

In the summer of 1988 medical wastes were found on a number of beaches around the country, including the beaches of Lake Michigan and Lake Erie. Both national and locally publicized coverage of these incidents heightened public concern and aroused fear of disease from possible exposure to contaminated medical waste. As a result, the public sent a clear message to its legislative representatives that they wanted special handling and disposal of medical waste. The continued findings of alleged improper disposal of medical waste further exacerbated public concerns about medical waste disposal practices and necessitated the intervention of public health authorities in Michigan and elsewhere (44 states have either passed medical waste legislation or promulgated new rules or revised rules and regulations). The new regulations contained in the federal Medical Waste Tracking Act of 1988 and in the Michigan Medical Waste Regulatory Act of 1990 are discussed at right.

Federal regulation

In response to the public outrage about medical waste mismanagement, Congress passed the Medical Waste Tracking Act of 1988. The law required the United States Environmental Protection Agency (EPA) to establish a two-year demonstration program to track medical waste in 10 states; New York, New Jersey, Connecticut and the seven states bordering the Great Lakes.

The demonstration program is intended to track 10 different categories of medical wastes from any facility that generates more than 50 pounds of waste per month. This tracking system will add considerable cost to the health care system. At the Management of Medical and Infectious Waste Conference held in Washington, DC, in December of 1988, EPA Deputy Director Jack Moore stated that "the law was passed because of the perception on the part of Congress that something was wrong. The American people simply will not tolerate the improper disposal of syringes, blood, body parts or specimens, in the future. People do not want to see wastes washed up on beaches, and they don't want to find them in dumpsters behind doctor's offices."

State regulation

When Governor James Blanchard chose to opt Michigan out of the federal Medical Waste Tracking Act program, he directed the Department of Public Health to promulgate "medical waste emergency rules" to regulate the handling and disposal of medical waste. These rules became effective on April 26, 1989, and represented an interim measure to require generators of medical waste to take the necessary precautions to safeguard the public health.

In March, 1990, a package of seven tie-barred bills crafted by the Michigan Legislature, known collectively as the Medical Waste Regulatory Act of 1990, were signed into law by the Governor, replacing the emergency rules. Key objectives of the Regulatory Act are: (1) to establish a program to regulate the handling and disposal of medical waste to protect the public health by preventing, to the extent possible public exposure to the risk of injury, infection or disease from improperly disposed infectious medical waste; (2) to alleviate public concern about medical waste mismanagement; and (3) to manage medical waste by methods that should not result in overly burdensome requirements.

The Regulatory Act mandates how producing facilities (generators of medical waste) must handle waste from the point that it becomes medical waste to the point of its ultimate disposal. These regulations require that the producing facilities take certain steps in handling, labeling, packaging, storing, transporting and disposing of the regulated medical waste and to prepare a management plan for such procedures. Regulated medical waste includes cultures and stocks of infectious agents, liquid human and animal wastes, pathological waste, sharps and contaminated waste from animals that have been exposed to agents infectious to humans.

The majority of physician offices generate the sharps category of regulated medical waste, some also generate cultures and stocks and blood and blood products. Still others may generate pathological waste. The schematic presented illustrates disposal methods for physician offices.

It should be noted that materials stained with blood or other body fluids are not included in the Act's definition of regulated medical waste. They can be treated as solid waste for the purpose of final disposal.

The Act considers physician offices which generate any of the five defined categories of medical waste as "producing facilities" and mandates these offices to register with the Department of Public Health and pay a registration fee. The Certificate of Registration is valid for three years. Failure to register with the Department is subject to a fine of $500, as is failure to develop a medical waste management plan for the producing facility. (See

Continued on page 43

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Continued from page 41

page..for sample plan). Other violations of the Act are subject to a fine up to $2,500 for each violation and $1,000 for each day the violation continues.

Producing facilities must separate the categories of medical waste at their point of origin into appropriate, properly labeled containers. Sharps must be placed into rigid, puncture resistant containers. Containers used to collect, store and transport regulated medical waste should be clearly labeled with a "biohazard" symbol or the words "medical waste" or "pathological waste" written in letters at least one inch high. Regulated medical waste cannot be stored on the premises of a producing facility for more than 90 days.

All categories of medical waste must be packaged in a manner that prevents accidental release in the office or at any time before ultimate disposal. Sharps must be transported for final disposal in a manner that retains the integrity of the sharps container. Sharps shall not be compacted. It's important to note that most refuse removal trucks are equipped with compactors and have the potential to crush the sharps containers and disperse their contents.

The Regulatory Act also requires physician offices which generate any of the categories of regulated medical waste to maintain on their premises a written medical waste management plan. The plan must describe the categories of medical waste handled, how they are handled, stored and disposed of by each producing facility. Additionally, the Act includes a training requirement. Each producing facility must train both its medical and nonmedical personnel who handle and dispose of medical waste. Training procedures, methods, materials covered, etc., should be reflected in the written medical waste management plan.

Summary

In Michigan, the medical care community has a long history of carefully managing infectious medical wastes within their facilities to control communicable diseases. Never the less, concerns have surfaced about health risks posed by medical waste because of the notoriety of reported incidents of improperly disposed medical waste that led to the promulgation of emergency rules and now permanent statutes.

As the environment reemerges as a national issue, the proper disposal of medical waste remains, at the very least, a highly visible and volatile part of this nation's solid waste crisis. To better develop appropriate controls for dealing with regulated medical waste, we will need to work together. Journal articles such as this provide an important opportunity to share and move forward our understanding of this problem so that we may all enjoy a safer and better environment.

Proper handling and disposal of medical waste will remain a public issue as long as wastes believed to be of medical origin are found on beaches or at unauthorized storage or disposal locations. Hence, compliance with the regulations for the handling, storing, treating, transporting and ultimate disposal of regulated medical waste by providers of health care in Michigan must be observed.

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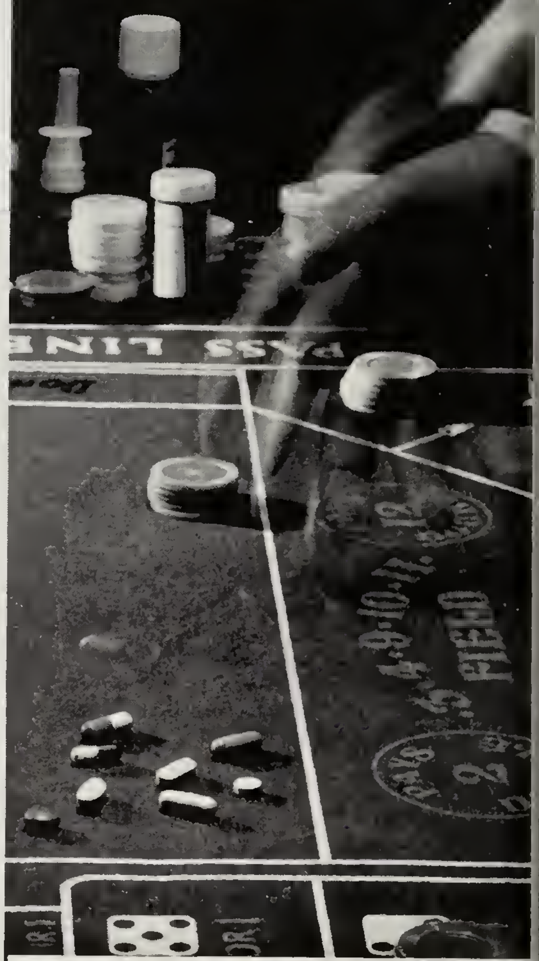

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Medical Waste Management Plan Requirements
Act No. 368 of the Public Acts of 1978
Part 138 Medical Waste Regulatory Act

Sample Plan

A producing facility shall have a written medical waste management plan on file on the premises within 90 days after registration. The medical waste management plan shall contain the following information, to the extent the information is applicable, to the producing facility.

Producing Facility Name: ____________________

Address: ____________________

Telephone: ____________________ Date: ____________________

Individual Responsible for the Management of Medical Waste:

____

Types of Medical Waste Handled (check applicable box)

☐ 1. Cultures and stocks of infectious agents and associated biologicals, including laboratory waste, biological production wastes, discarded live and attenuated vaccines, culture dishes, and related devices.

☐ 2. Liquid human and animal waste, including blood and blood products and body fluids, but not including urine or materials stained with blood or body fluids.

☐ 3. "Pathological Waste" means human organs, tissues, body parts other than teeth, products of conception, and fluids removed by trauma or during surgery or autopsy or other medical procedure.

☐ 4. "Sharps" means needles, syringes, scalpels, and intravenous tubing with needles attached.

☐ 5. Contaminated wastes from animals that have been exposed to agents infectious to humans, these being primarily research animals.

.Describe for each type of medical waste handled, segregation, packaging, labeling, and collection procedures used.

.Describe the use and methods of on-site or off-site storage.

(please see other side)

.Describe the use and methods of on-site or off-site decontamination.

.Describe the use of on-site or off-site incineration.

.Indicate the corporate or other legally recognized business name of solid waste haulers who transport medical waste for the producing facility.

.Indicate (by name) the use of sanitary landfills, cemeteries, and other disposal sites.

.Describe the measures to minimize exposure of the facility's employees to infectious agents throughout the process of handling and disposing of the medical waste, including, where applicable, the use of protocols, procedures and training, personal protective devices and clothing, physical containment or isolation devices or systems, and prevention or control of aerosols.

It's Important to Note:

– A medical waste management plan shall comply with the requirements of the Medical Waste Regulatory Act.

– A producing facility shall update a medical waste management plan each time there is a *change* in either of the following, within 30 days after the change occurs:

  a. A person or site named in the plan.
  b. The type of medical waste handled or the methods of handling medical waste at the facility.

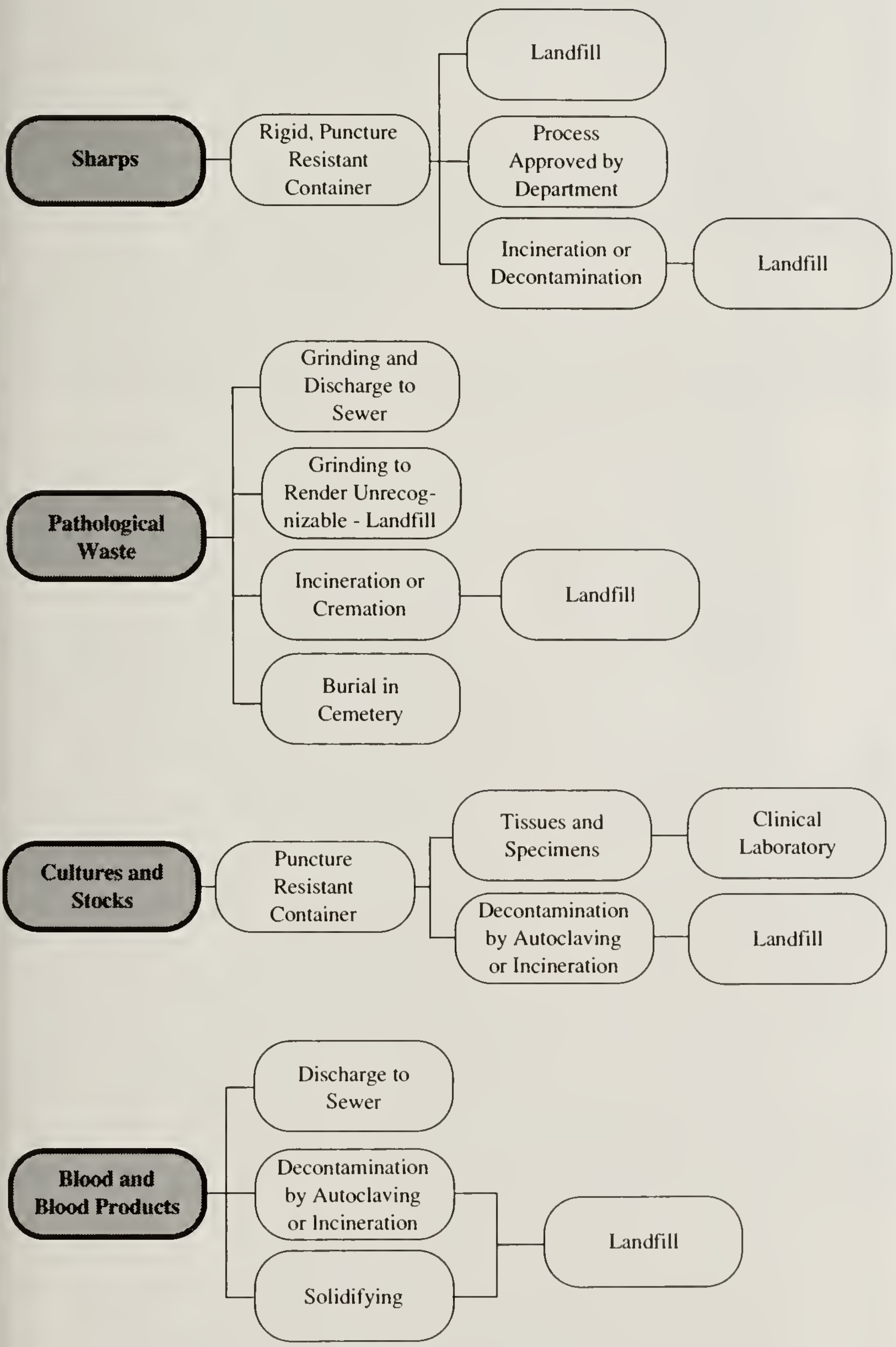
– A producing facility shall comply with its medical waste management plan.

– Upon request, a producing facility shall make its medical waste management plan available to the department.

– Upon receipt of 24 hours' advance notice, a producing facility shall make its medical waste management plan available to an employee of the producing facility for inspection on the premises or provide a copy of the medical waste management plan to the employee.

LC:lh
4-2-90

A Medical Waste Disposal Guide for physician private practice offices


Sharps
Rigid, Puncture Resistant Container
Landfill
Process Approved by Department
Incineration or Decontamination
Landfill
Pathological Waste
Grinding and Discharge to Sewer
Grinding to Render Unrecognizable - Landfill
Incineration or Cremation
Landfill
Burial in Cemetery
Cultures and Stocks
Puncture Resistant Container
Tissues and Specimens
Clinical Laboratory
Decontamination by Autoclaving or Incineration
Landfill
Blood and Blood Products
Discharge to Sewer
Decontamination by Autoclaving or Incineration
Solidifying
Landfill

NOTE:
- Separate categories at point of origin into appropriate containers.
- Package, contain and locate to prevent release of medical waste at the producing facility or at any time before ultimate disposal.
- Label containers with **biohazard symbol** or the words **"medical waste"** or **"pathological waste"** in letters at least one inch high.
- Do not compact or mix medical waste with other medical waste prior to decontamination, incineration, and disposal.
- Do not store on the premises for more than 90 days.

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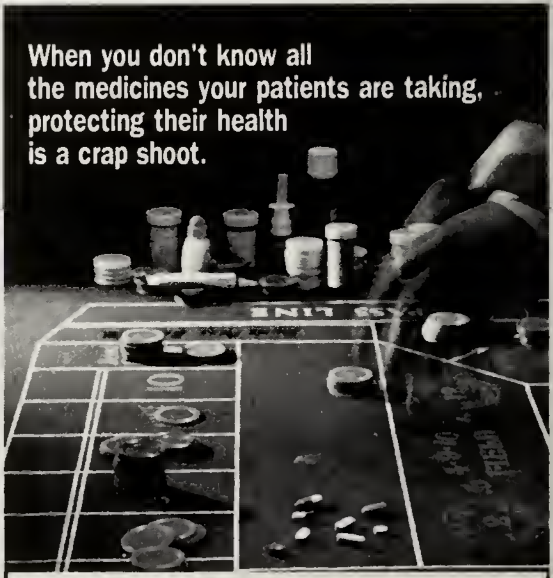

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AIR FORCE

MSMS Represents Member's Views In Amicus Court Cases

By Richard D. Weber
and Jeanne Geha Swanson

MSMS has expressed its views to Michigan's appellate courts on a number of legal issues which are of importance to Michigan's medical community. The following brief synopsis of the cases in which MSMS has participated over the past six years is provided to keep you informed of MSMS amicus curiae activity.

Palenkas v Beaumont Hospital

In *Palenkas,* the Trial Court reduced a medical malpractice verdict for the plaintiff from $1.2 million to $800,000 pursuant to a procedure known as "remittitur." On appeal, the Michigan Supreme Court was asked to determine whether the remittitur was proper. Up until that time, the "standard" for determining whether a verdict was excessive was the highly subjective "shock the conscience" test i.e. does the verdict shock the judicial conscience? MSMS urged the Supreme Court to reject that standard in favor of a more objective inquiry designed to determine whether the verdict "exceeds the highest amount the evidence will support."

In this long-awaited decision, the majority opinion rejected the "shock the conscience" test as inappropriate because "it merely involves an expression of the trial judge's personal values and subjective beliefs and in no way relates to the actual conduct of the trial." The Court held that the inquiry to be made is whether the amount awarded exceeds the highest amount the evidence will support. A comparison of jury awards in analogous cases may be considered as providing an "objective means of determining the range of appropriate awards in such cases." Other objective inquiries include whether the verdict was the result of improper methods, prejudice, passion, partiality, sympathy, corruption, or mistake of law or fact.

Monusko v Burns Clinic

MSMS joined the defendants in *Monusko* in asking the Michigan Supreme Court to review and reverse a Court of Appeals decision which, for the first time, recognized the existence of "preconception tort" as a theory of recovery in this state. The decision grants a cause of action to a child who is injured by allegedly negligent conduct which occurred prior to the child's conception. MSMS argued that this decision ignores the usual prerequisites to a medical malpractice action by allowing a physician to be sued by a person with whom no doctor-patient relationship existed. It also creates a conflict between a doctor's duty to advise appropriate treatment for his patient and the risk that treatment may pose to the patient's yet-to-be conceived children. It indefinitely extends the period of time during which a physician may be subject to suit (effectively obliterating the statute of limitations in such instances) and runs counter to the legislature's recognition of the need for tort reform rather than expansion.

The Supreme Court refused to decide this issue, leaving the Court of Appeals decision standing as the law in Michigan.

Palazzo v Teasdall

The plaintiff physical therapist in *Palazzo* recovered a substantial verdict against the defendants for tortious interference with a business relationship pursuant to which he performed electromyography upon referral from various physicians. To determine the propriety of that verdict, the Court of Appeals had been called upon to determine whether Palazzo's performance of electromyography was proper. MSMS filed an amicus curiae brief in support of the proposition that electromyography is an inherently diagnostic procedure which constitutes the practice of medicine and is outside the scope of a physical therapy license. Although this question has been bantered about by the affected professional associations for a number of years, it has yet to be definitively determined. The case was settled before the Court of Appeals rendered a decision.

Morris v Metriyakool

The Michigan Supreme Court upheld the Medical Malpractice Arbitration Act against constitutional attack in *Morris.* It had been argued that the inclusion of a physician on the three member arbitration panel violated constitutional guarantees of due process. It had also been argued that the agreement was an "adhesion contract" and was otherwise unconscionable. The Supreme Court rejected these attacks. The amicus brief filed by MSMS supported the statute in all respects.

McKinstry v Valley Obstetrics & Gynecology Clinic

The enforceability of arbitration agreements which conform to the requirements of the Medical Malpractice Arbitration Act was before the Michigan Supreme Court in *McKinstry.* As amicus curiae, MSMS asserted that parties seeking to avoid an arbitration agreement which otherwise conformed to the statute, bore the burden of proving the agreement's invalidity. On another issue, MSMS argued that an unborn child is bound by an arbitration agreement signed on its behalf by a parent. The Michigan Supreme Court favorably decided both issues.

Duvall v Goldin

The Michigan Supreme Court declined a request to determine the propriety of a Court of Appeals decision which held that a physician's duty of care extends to unidentifiable third persons who are harmed by the physician's treatment of a patient. Plaintiffs were injured in an automobile accident which occurred when their vehicle was struck by the defendant-doctor's

Continued on next page

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patient. It was alleged that the defendant-doctor knew or should have known that his patient had previous epileptic seizures as to which he had failed to prescribe or continue anti-epileptic medication and/or instruct him not to operate a motor vehicle. The Supreme Court's refusal to decide the issue left the Court of Appeals decision standing.

Attorney General v Bruce

The Michigan Supreme Court affirmed the confidentiality of the records of a hospital peer review committee and prohibited their discovery by the Board of Medicine and the Department of Licensing and Regulation. As amicus curiae, MSMS asserted that the Michigan Public Health Code, which requires licensed hospitals to conduct continuing internal peer reviews of its professional staff, provides for the confidentiality of information collected by a peer review committee and protects it from disclosure through the judicial discovery process. The rationale for this protection is to maintain an uninhibited and candid atmosphere for peer review committee discussions to improve the care and treatment of hospital patients.

Monty v Warren Hospital

This case involved the disclosure of peer review committee records in a malpractice case. The Michigan Supreme Court reversed a Trial Court order which required committee records to be produced in open court. The Court would not accept the proposition that records are confidential under the peer review statutes merely because the hospital says they are. The Supreme Court held that the records must be produced for a private analysis by the presiding judge to determine whether they really fall within the peer review function. If the Court determines that they are truly peer review records, their confidentiality will be maintained, as argued by MSMS.

Jordan v Sinai Hospital

The Michigan Supreme Court rejected a request in *Jordan* to review a Court of Appeals decision which barred a defendant in a medical malpractice action form informally interviewing the plaintiff's physicians absent permission from the plaintiff. As amicus curiae, MSMS had urged the Supreme Court to accept the appeal and reverse the Court of Appeals decision because the physician-patient privilege is waived when the patient files suit and executes medical records authorizations. Ex parte (outside the presence of the opposing party) interviews had been effectively utilized as an informal and inexpensive means of discovery for years. The Supreme Court refused to decide this issue in *Jordan* but subsequently agreed to hear the same issue in another case. See *Domako* v *Rowe* below.

Domako v Rowe

In *Domako*, the Michigan Supreme Court will finally decide whether informal ex-parte interviews between defense counsel and non-party treating physicians violate the physician-patient privilege. This is the issue the Supreme Court refused to decide in *Jordan* v *Sinai Hospital*, where the Court of Appeals barred such interviews absent the plaintiff's consent. The Court of Appeals decision in *Domako* upheld the ex-parte interviews and certified this conflict for Supreme Court review. MSMS filed an Amicus Brief supporting the propriety of ex-parte interviews. Oral arguments have been held and the matter is under consideration.

In The Matter of Joelle Rosebush

This "right to die" case is pending in the Court of Appeals after the Supreme Court rejected the parties' attempt to place the issue directly before the high Court. It involves the Oakland County Prosecutor's appeal of a Circuit Court decision authorizing the parents of 11-year old Joelle Rosebush to withdraw life support from their child notwithstanding the fact that "brain death" under the Michigan Determination of Death Act had not occurred. Physicians who testified during the lower court proceedings diagnosed Joelle's neurologic injury as a persistent vegetative state that offered no chance for recovery. She did not respond to stimulation in even a remotely cognitive manner. However, she was not considered "brain dead" pursuant to Michigan's statute because part of her brain stem was not irreparably injured.

This case has now been fully briefed and is awaiting oral argument. In the interim, the United States Supreme Court has essentially determined that issues regarding the withdrawal of artificial life support should be resolved by the states, *Cruzan exrel Cruzan* v *Director, Missouri Department of Health*. Further, provisions of the recently enacted Omnibus Reconciliation Act of 1990 will soon require certain hospital, nursing homes and long-term care facilities to advise patients regarding their right to make medical care decisions. MSMS has recently joined the parties' request for an expedited hearing of this matter.

Hill v Kokosky

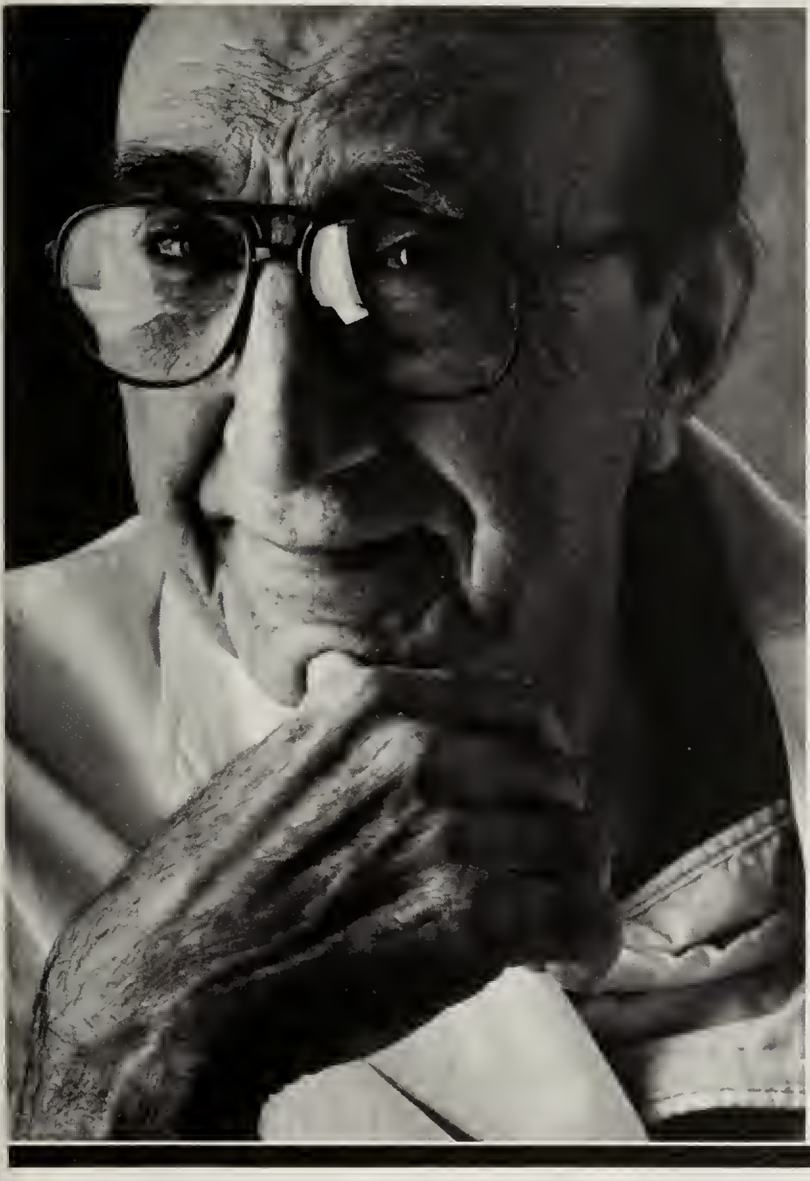
In this important case, the Court of Appeals refused to extend potential malpractice liability to physicians with whom a treating physician had merely conferred regarding a patient. It held that informal discussions between a treating physician and other physicians did not give rise to a physician-patient relationship between the patient and the conferring physicians. MSMS filed an amicus brief asserting that the imposition of liability in such instances not only conflicted with governing law but also countered the public policy of this state by (1) discouraging the free exchange of ideas among physicians regarding patients and treatment alternatives, and (2) expanding malpractice liability at a time when the legislature has deemed tort reform necessary. The plaintiff's application for leave to appeal to the Michigan Supreme Court is pending.

Bissell v Kommareddi

This case could have a far-reaching impact on the 1986 tort reform legislation. Plaintiff is challenging the constitutionality of the statute of limitations which governs the time within which a minor's claim for medical malpractice must be asserted. The new legislation provides that a victim of medical malpractice who is less than 13 years of age must bring suit by his or her 15th birthday, but if the minor is over 13 years of age he or she generally has until two years after the malpractice occurred or within six months of discovering the claim, in which to bring suit. Plaintiff's constitutional challenge to this provision is two-fold. Plaintiff first alleges that the provision violates the equal protection clause of the 14th Amendment to the US Constitution and Article I, Section II of the Michigan Constitution because it treats minors with malpractice claims differently from minors asserting other types of tort claims. Minors with other claims have until their 19th birthday in which to bring suit. Plaintiff also argues that the statute violates due process because it allegedly operates to deny minor medical malpractice litigants access to the courts.

This case is currently pending in the Michigan Court of Appeals. MSMS will be filing an amicus brief in support of the constitutionality of the statute. ■

Richard Weber and Joanne Swanson are attorneys with Kerr, Russell and Weber, Detroit.



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Leelanau Memorial

One small hospital's frustrations in delivering health care

By James A. Kolberg, MD
James Packard and Brian Kaser

Editor's note: The MSMS Task Force on Rural Health Care, chaired by Fred W. Bryant, MD, Troy, presents the following article on Leelanau Memorial Hospital as an example of the challenges facing small rural hospitals in Michigan.

Leelanau Memorial Hospital is a "typical" rural community hospital. Located in Northport in rural Leelanau County, the hospital was founded 34 years ago. It is a private charity, and long has been the object of physician and community support, with donations averaging $200,000 per year. Sprinkled throughout the hospital's history are many stories, almost legends, about individuals who came forward to provide volunteer services or funds for capital and operating expenses in lean times. Its patrons include individuals from all walks of life, of all degrees of fame.

The hospital serves its community's needs with an emergency room, radiology and laboratory services, public education programs, 33 acute care hospital beds, and a 61-bed hospital-attached long-term care unit.

Over the last five or six years, the hospital has struggled, as many rural hospitals have done. In just the last few years, however, severe payment reductions by public and private payers, rapid and capital-intensive changes in medical technology and treatment, and rural population shifts in Leelanau County have created operating deficits unparalleled in the hospital's history. Even the continuing support of its medical staff and the generosity of its community supporters have been unable to cover the accumulating losses.

The hospital developed a strategic plan, having three primary points. First, the plan resolved that the hospital should keep the acute care services which are central to its identity as a hospital and which "anchor" its role in the community. Second, the plan proposed to convert or diversify excess and unneeded space in the hospital, to offer a greater range of services to the community and, if possible, to raise revenue. Third, the plan proposed affiliation with a major medical center, giving the hospital access to combined, more economical support services, such as purchasing and financial management. The affiliation would also make the hospital, which is physically somewhat isolated, an active participant in the region-wide planning of a significant health services system.

Several of the hospital's acute care hospital beds were never filled with patients. Consistent with the strategic plan, the hospital sought new uses for these unused rooms, to provide needed health care services to the community and to provide revenue sources that could keep the institution viable.

The hospital's 61-bed long-term care unit had been in service since 1972. Highly regarded in the community, the hospital's 61 beds were nearly always full, with a waiting list that averaged 15 persons. The self-evident choice was to convert some of the acute care beds to long-term care usage. The chief of surgery and the rest of the medical staff supported the change fully.

The Michigan Department of Public Health, which allocates the development of health care facilities through its certificate of need system, had declared that Leelanau County needed 13 more long-term care beds than were in existence at the time. The way appeared clear for implementation of the hospital's plan.

In September 1988, the hospital initiated a request for a certificate of need to close acute care beds and to create 11 of the needed 13 long-term care beds. In January 1989, the hospital's formal appli-

Continued on page 57

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Continued from page 55

cation was submitted. On its face, the application documented full compliance with all requirements for the certificate of need.

After examining the certificate of need application and requesting some further information, the Department of Public Health formally accepted the application on March 1, 1989.

The state denied the hospital's application on July 28, 1989.

The denial of the hospital's application came as a surprise. The explanation was that a commercial facility's application to build 100 new long-term care beds in the county had been denied more than a year before, but was under appeal. Those 100 hypothetical beds, though never to be built, were treated as if they existed. The hospital was hostage, in a sense, to the MDPH concern that its earlier decision was not sound enough to hold up in court, and that not 100 but 111 "extra" beds would be built in the County.

The hospital immediately appealed the decision to the reviewing agency. A great deal rested on the seemingly simple legal question of whether the 100 beds "under appeal" should stand against the hospital's application. The commercial facility had requested that its appeal hearing be adjourned indefinitely. That move ensured the Leelanau case would wait at least two more years before it could be heard. The bureaucratic process threatened to swallow the project in the vastness of its delay.

The administrative law judge ruled for the hospital in January, 1990. Victory seemed assured. To the hospital's surprise, the Department of Public Health retrenched and asserted new grounds for the denial of the application, a rationale that it had not relied upon or even mentioned in its first decision. It insisted upon a trial on its new issue. With economics and time against it, the hospital's victory was slipping away.

The hospital turned to its state senator and representative, both of whom expressed confidence in the merit of the hospital's position. The democratically controlled Department of Public Health remained obdurate in the face of the Republican legislators' entreaties.

The political process expanded to include the owner of the proprietary facility. The Department's legal position was such that the owner held the power voluntarily to relinquish the "priority" of his facility's application over that of the hospital and give the hospital the owner's place in the bureaucratic line.

After several weeks of negotiation among the Department, the hospital, legislators, and the developer of the other project, agreement was reached. After an extra six months of delay, and fees and costs equal to the original projected project cost, the hospital was about to get a CON for 11 beds that the authorities had agreed from the first were needed in the County. The breakthrough came not from the Department, but from the owner of the commercial project. It came not at the cost of the Department, but at the legal and political cost of the hospital and the other developer.

In the very last weeks before the signing of the Settlement Agreement, the Department of Social Services issued a bulletin unilaterally declaring that effective July 1, 1990, it would reduce payment for all hospital attached long-term care units for which a CON was not issued before that date. The hospital feared the elephantine pace of the Department's settlement procedures would produce a CON too late to realize the higher payment rate. The difference, approximately $30 per day per bed, was the difference between success and shortfall. On the last day before the rate reduction, departmental personnel returned from vacation, found the hospital's lawyer waiting at the door, and signed the necessary documentation.

Postscript: The hospital has been readying the acute care rooms for long-term care by redecorating and making other adjustments. Census in the 61 beds had been lower than usual, but the hospital planned to have all 72 beds (the original 61 plus the converted 11) filled by March of this year. Yet, success is not assured. The state is proposing a 30 percent cut in the hospital based long-term care units' payment. This would mean a $400,000 to $525,000 annual payment reduction to Leelanau Memorial Hospital, and, like the near-failure of the state to settle the CON case on time, could ruin the project financially. ■

Doctor Kolberg is chief of surgery and Doctor Packard is administrator, Leelanau Memorial Hospital. Mr. Kaser is an attorney with Foster, Swift, Collins & Smith, Lansing.

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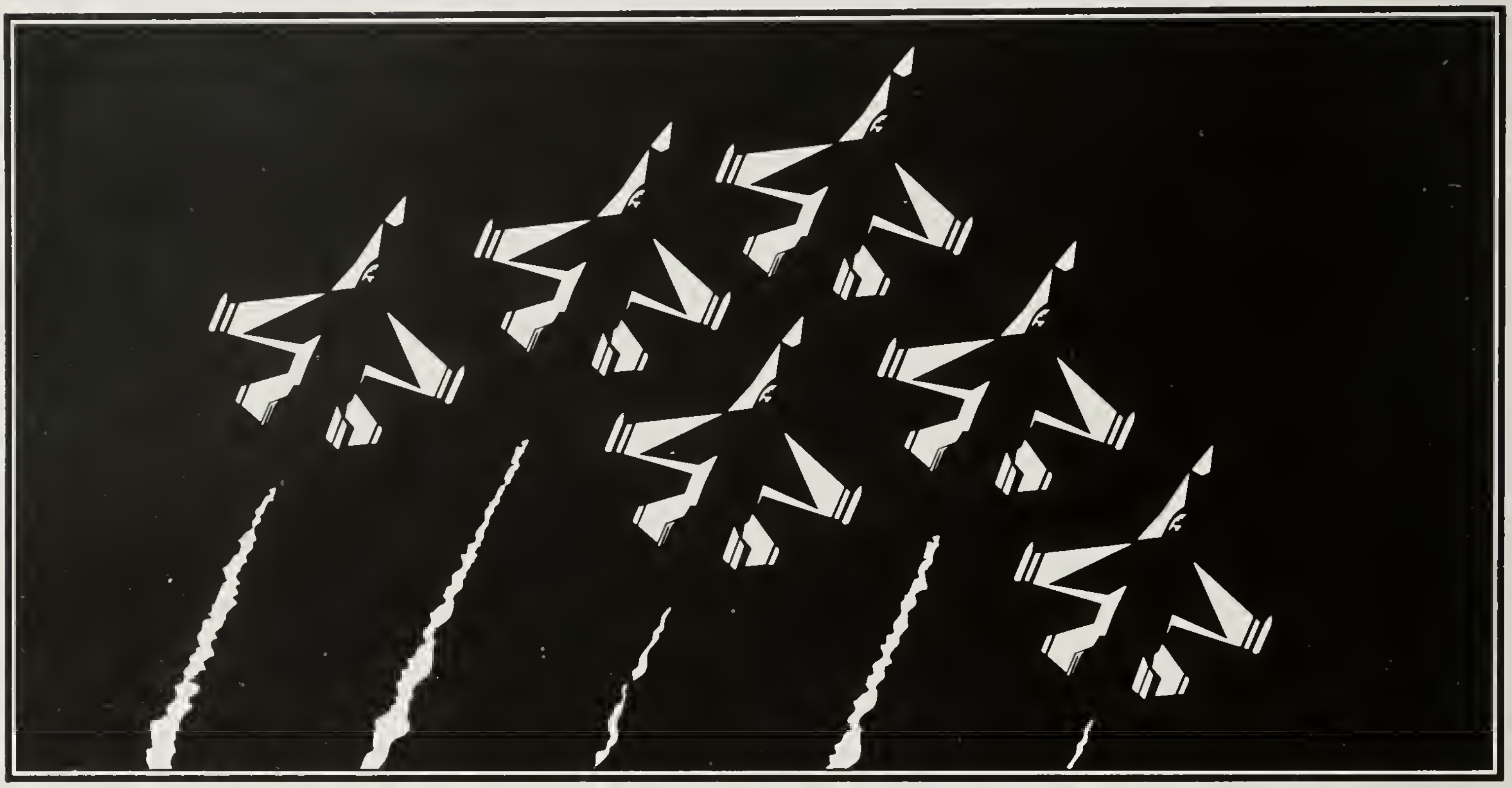

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Michigan Society of Internal Medicine

Providing comprehensive care to adults

By Ralph D. Ward

The following is the fourth in a series of articles on medical specialty societies in Michigan.

Internal medicine is an intense specialty, emphasizing one-on-one patient contact and shrewd medical detective work. Yet many feel it is undervalued, both in professional estimation and reimbursement. It is fairly new on the scene as a recognized specialty, but encompasses many of the basics of medical practice, including cardiology, gastroenterology, allergies and hematology. "The best definition (of an internist) is someone who provides comprehensive medical care to adults," says John Maurer, MD, president of the Michigan Society of Internal Medicine. "The internist takes the role of being a personal physician seriously."

The Michigan Society is a branch of the American Society of Internal Medicine. The ASIM was formed in 1956 to deal with the shared concerns of practicing internists on such issues as quality of care, availability, cost of services and the environment. The latter issue, currently experiencing a resurgence of interest, has been a historic concern of internists. James Hall, MD, who founded the Michigan chapter in 1957, was a strong environmental activist, and a patron of many early conservation groups.

This emphasis on the day-to-day influences on health, and how physicians should respond, is a hallmark of internal medicine. "Other specialties and their associations tend to concentrate on clinical concerns. Ours was the first group to recognize that social issues affect health, and to work on how medicine interacts with government, insurers, and regulators."

Involvement in health care issues strong

This emphasis on "cause and effect" medicine has seen the internist's association involved in a number of health issues over the years. The group has been a long-term and effective opponent of tobacco use, urging doctor's office smoking bans and lobbying for smoking cessation programs. The national society has also fought hard for a realistic government policy on indigent care, and was a supporter of the recent Medicare Catastrophic Benefits Bill. Strong stands on

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availability of AIDS treatment, and growing emphasis on the health needs of the expanding older population, are other internist passions.

But the internist's association also has a strong interest in a more fundamental concern — staying close to patients. The internist is a physician who is "interested in dealing with people directly," according to Doctor Maurer, "who likes working one-on-one, taking care of people." Another aspect of this concern is a talent for diagnosis. "Internists enjoy the challenge of problem solving. We consider ourselves skilled diagnosticians; we like being detectives." These cognitive services, the "thinking and caring" skills that bring life to the concept of a "personal" physician, are considered the internist's greatest assets.

But these cognitive services, so necessary to comprehensive medical care, are hard to value objectively. Surgery and other procedures have easily quantified services and outcomes, but how can we value the time-consuming give-and-take required for personal patient care? According to the internist's group, we don't value it — and reimbursement scales reflect this lack of respect. "One of the major issues we face is better recognition of cognitive services," says Doctor Maurer. "Over the past 25 years a growing disparity of income has evolved between cognitive services and surgery and other technical procedures. We have to recognize the value of the internist's services."

This push for "comparative worth" in reimbursement has been a major initiative for the ASIM and the Michigan branch for several years, and their work is showing results. Among Medicare changes approved by Congress two years ago was a shift to Resource Based Relative Value Scale (RBRVS) reimbursement for services. Under such a system, a variety of considerations, including time, complexity, investment in education, and liability dangers, will be factored into Medicare reimbursements. The system, to begin next year, will see an approximate 10 percent increase in internist reimbursement. However, RBRVS will also bring a proportionate decrease in surgical reimbursement, which is not a prescription for happy surgeons. "It took a lot of political work and arm twisting to gain an agreement on RBRVS," admits Doctor Maurer. "But one reason for a consensus was that everyone realized the inequities had grown so great."

The national society offers other services customized to the needs of internists. Publications, including the *Intercom* monthly newsletter, the *Internist* magazine, and a patient newsletter program, inform and educate. The ASIM also effectively advocates the interest of internists with the public, the government, and third-party payers.

A brighter future for internists

The reimbursement issue, and overall lack of regard in the medical community for the internist's skills, have led to stagnation in the number of internists operating in the state. Says Doctor Maurer: "We've had difficulty attracting medical students, and the state and national numbers aren't growing as much as necessary, especially with the growing older population." But with changes in reimbursement — and, it's hoped, changes in attitudes — the future looks brighter for internists. "I don't think internists got the respect they deserved in the past, but now we're coming on strong." ■

Ralph Ward is a Lansing-based freelance writer.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

8-11, Mackinac Island Imaging Conference. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 21 hours Category I Credit.

14-17, 5th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48109-9869, (313) 936-1641. **Approved for:** 13 hours Category I Credit.

25-26, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** Munson Medical Center. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386, (616) 922-9546. **Approved for:** 9-11 hours Category I Credit.

28-31, 17th Annual Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

August

8-11, Cardiology Update. Location: Grand Hotel, Mackinaw Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 12 hours Category I Credit.

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CATEGORY I COURSES

10-11, Endocrinology and Diabetes Update. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine and Michigan Diabetes Research and Training Center. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 8 hours Category I Credit.

11-14, Internal Medicine Update. Location: Grand Hotel, Mackinaw Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

15-17, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 13 hours Category I Credit.

September

14, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 6 hours Category I Credit.

30-10/1, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. **Contact:** Julie Jones, Office of Continuing Medical Education, G1100 Towsley Center, P. O. Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 14 hours Category I Credit.

October

25-26, Advanced Cardiac Life Support Instructors Course. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsors:** Michigan Chapter of the American College of Emergency Physicians and American Heart Association of Michigan. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 16 hours Category I Credit.

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MEETINGS

MSMS Meetings

July

10, MSMS/MPMLC Risk Management, Bay Valley, Bay City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

11-14, MSMS Mid-Summer Board of Directors Meeting, Boyne Highlands, Boyne City, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

15, MSMS/MPMLC Current Issues in Risk Management, Waterfront Inn, Traverse City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

17, MSMS/MPMLC Current Issues in Risk Management, Troy Hilton, Troy, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

23, MSMS/MPMLC Current Issues in Risk Management, Weber's Inn, Ann Arbor, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

25, MSMS/MPMLC Current Issues in Risk Management, Grand Rapids Regional Center, Grand Rapids, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351

30, MSMS/MPMLC Current Issues in Risk Management, Wayne County Medical Society, Detroit, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

August

6, MSMS/MPMLC Current Issues in Risk Management, Marquette Medical Society, Marquette, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

8, MSMS/MPMLC Current Issues in Risk Management, Bay Valley, Bay City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

12-16, Conomikes Medical Office Management Institute, Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

13, MSMS/MPMLC Current Issues in Risk Management, Troy Hilton, Troy, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

19, MSMS/MPMLC Current Issues in Risk Management, Waterfront Inn, Traverse City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

21, MSMS/MPMLC Current Issues in Risk Management, Grand Rapids Regional Center, Grand Rapids, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

27, MSMS/MPMLC Current Issues in Risk Management, Weber's Inn, Ann Arbor, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

29, MSMS/MPMLC Current Issues in Risk Management, Wayne County Medical Society, Detroit, MI. Contact: Julie Smith or

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MEETINGS

MSMS Office of Physician Education, (517) 337-1351.

September

10, MSMS/MPMLC Current Issues in Risk Management (evening program). Novi Hilton, Novi, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

11, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

11, MSMS Practice Management Seminar "Improving Your Practice Productivity And Performance In The 1990's." Hyatt Regency, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

12, MSMS/MPMLC Current Issues in Risk Management (evening program). Sheraton, Lansing, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

12, MSMS Practice Management Seminar "Improving Your Practice Productivity And Performance In The 1990's." University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

13-14, MSMS Practice Management Seminar "Starting Yourself In Medical Practice." Amway Grand, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

14-15, MSMS Practice Management Seminar "Improving Your Practice Productivity and Performance In The 1990's." Grand Hotel, Mackinac Island. Contact: MSMS Office of Physician Education, (517) 337-1351.

18, MSMS/MPMLC Current Issues in Risk Management (evening program). Port Huron Hospital, Port Huron, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

21, "Balancing The Dimensions Of Your Life," a seminar for all physicians, residents, medical students and auxilians, sponsored by the MSMS Committee on Concerns of Women Physicians. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24,25,26, MSMS Practice Management Seminar "Advanced Coding and Reimbursement." September 24 at Holiday Inn, Marquette, MI; September 25 at the Grand Traverse Resort, Traverse City, MI; and September 26 at Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

25,26, MSMS Practice Management Seminar "Medical Office Management for the Physician's Spouse." September 25 at Ritz Carlton, Dearborn, MI; September 26 at Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education or Dawn Reha, (517) 337-1351.

October

1,2,3, MSMS Practice Management Seminar "How to Improve Third-Party Reimbursement and Coding." October 1 at Dearborn Inn, Dearborn, MI; October 2 at Bay Valley Inn, Bay City, MI; October 3 at the University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

8,9,10, MSMS Practice Management Seminar "ICD-9CM Diagnosis Coding - How To Do It Right." October 8 at Grand Traverse Resort, Traverse City, MI; October 9 at Amway Grand Plaza, Grand Rapids, MI; October 10 at Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

16, MSMS Practice Management Seminar "Retirement Planning." the University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

22,23,24, MSMS Practice Management Seminar "1991 BCBS Medicare Update Series." October 22 at the University Club, East Lansing, MI; October 23 at Dearborn Inn, Dearborn, MI; October 24 at Bay Valley Inn, Bay City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24, MSMS Practice Management Seminar "Kerr, Russell, and Weber - Health Law Update (1/2 day)." Ann Arbor Regent, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

29, AMA-MSMS Medical Office Staff Training Series. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

November

12-14, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, MI. Over 50 courses offered. Contact the MSMS Office of Physician Education, (517) 337-1351 for a complete meeting program.

National Specialty Society Meetings

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

October

10-13, American Society of Internal Medicine 35th Annual Meeting. Contact: Lisa Derby, (202) 289-1700 ext. 615.

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References:
1. A. Morales et al., New England Joumal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Joumal of Urology 128: 45-47, 1982.

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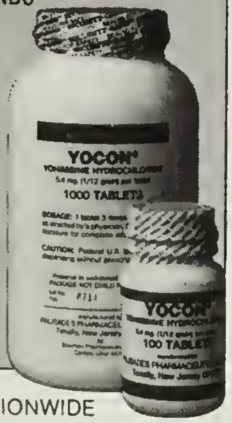

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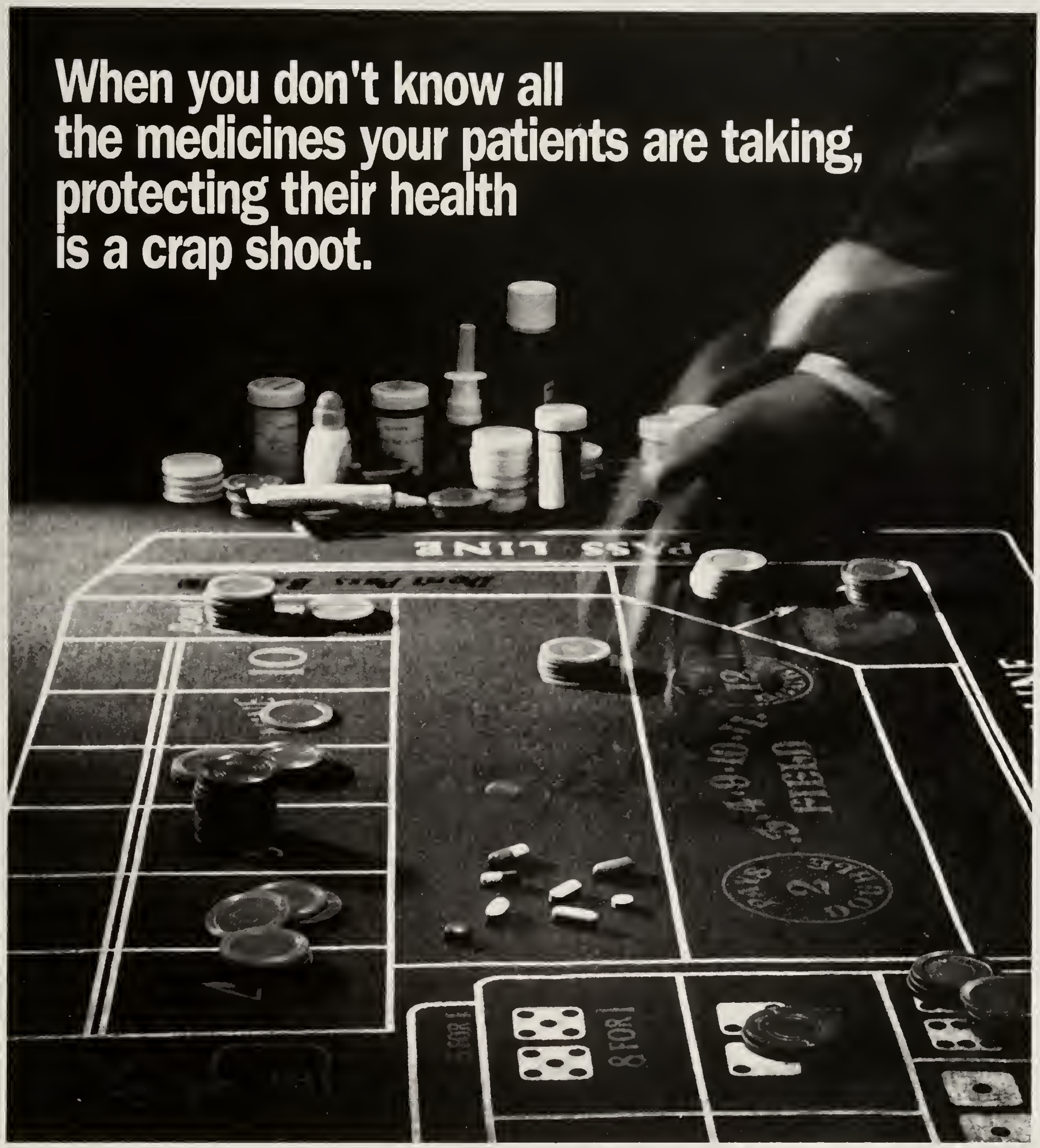
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Continued on page 71

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Medsys	31
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Northern A-1 Services	48
Oakwood Hospital	68
Palisades Pharmaceuticals	66
PC Medical	57
Physician Service Group	1
PICOM	33-34, 70
PMG	61
Prescott, Ball & Turben	47
Rice Clinic	71
Scientific Data Management	26
Shearson Lehman Bros.	18
St. Luke's	5, 72
US Air Force	50
US Army	64
Valley City	39
Women's Health Center	71

PRESIDENT'S PAGE

Medical ethics through the ages

By Robert D. Burton, MD

A treasured item from antiquity sitting in my bookcase at home is a black diodrite stela that reminds me, despite our magnificent medical advances, we physicians still face many age-old dilemmas.

This artifact is a seven-inch high replica of the original seven-foot pillar — now in the Louvre in Paris — inscribed with the Code of Hammurabi.

King Hammurabi, who ruled the vast Babylonian empire nearly 4,000 years ago, was a methodical, meticulous monarch who revamped the country's legal system with his new Code. The code's guiding principle was that "the strong shall not injure the weak."

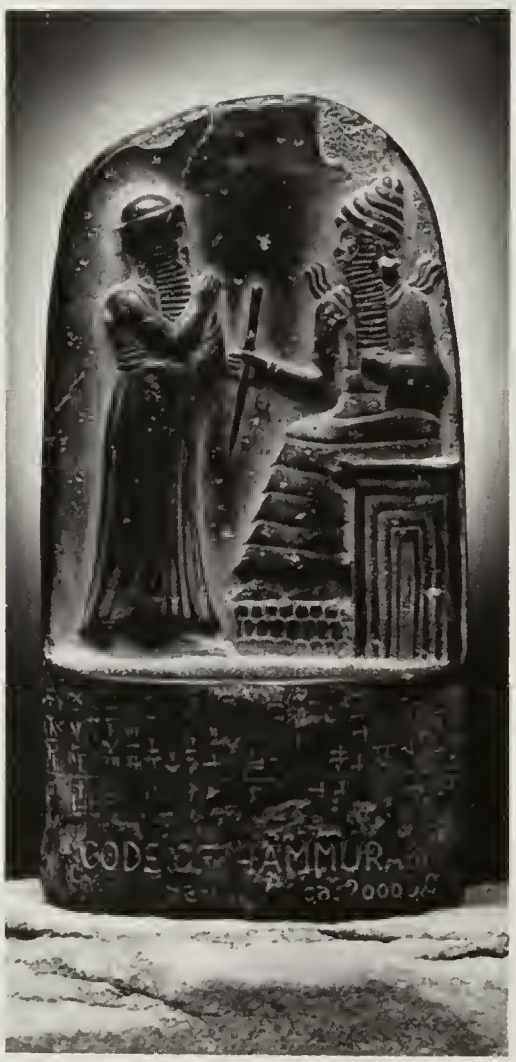
The code covered all aspects of Babylonian life, including for the first time in history, the codification of the practice of medicine. It set fees for physicians and it set fairly harsh penalties for physicians who injured patients.

Our state legislature — 4,000 years after Hammurabi — is currently looking at a bill to outlaw physician assisted suicide. This bill was quickly developed in the wake of Doctor Kevorkian's lethal demonstration of his "suicide machine" last May.

The bill has passed the Senate, but it's tied up in the House Judiciary Committee where it is likely to lanquish indefinitely.

In the meantime, MSMS has taken the initiative to begin developing an ad hoc committee of interested parties to discuss this issue, outside of the legislature. In July, MSMS will host representatives of the medical profession, the clergy, the hospitals, the legislature, the legal profession, ethicists and others, to discuss an issue raised by Hammurabi four millenia ago and reiterated by Hippocrates 2,500 years ago — "I will give no deadly medicine to any one if asked, nor suggest any such counsel."

Ideally, there would be no ethical problem here if we were the gods the public sometimes wants us to be. We would make our decisions over life and death and that would be it. Ideally, everyone would die peacefully in their sleep with no lingering, painful, costly disease. No options to explain, no choices to make.



A difficult reality

But we realize there is a difficult reality here. We have the technology to keep patients alive — despite the quality of their lives — for as long as they or their family want to keep the machines running. We have a growing older population, a group that has witnessed the miraculous advances in medical technology that many have grown to fear because of its dehumanization. Many people have become more concerned about quality of life than length of life; people who want their lives to end rather than continue a painful, debilitating existence.

Several of the cases that have become ethical and legal milestones may have been resolved if the patients had made known their wishes concerning their own medical care before they became incapacitated.

A new Michigan law, long supported by MSMS, will be helpful. Finally passed by the legislature in December after 16 years of effort, it is called the Patient Advocate Act of 1990, or Durable Power of Attorney for Health Care.

The new law allows anyone over 18 years old to appoint someone else to be their "patient advocate" to make decisions for them if they become incapacitated. The patient advocate may make decisions regarding care and custody and about life and death issues such as removing life support and artificial nutrition and hydration.

Shortly after the law passed, MSMS joined with the State Bar of Michigan, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons to develop a form with which to appoint a patient advocate. The forms have been printed and now MSMS is encouraging physician offices to order a quantity from MSMS to distribute to their patients. Order forms appear in *Medigram*. One is included in this month's issue of *Michigan Medicine* on page 37.

If everyone in the state would take the time to complete the form to appoint a patient advocate, many of the most painful, uncertain decisions that physicians, hospitals and family members face with incapacitated patients could be eliminated.

Of course, I don't expect our ad hoc committee on assisted suicide, or the Patient Advocate Act and our designation forms to solve all of the problems in this legally, ethically and morally gray area.

But I do think King Hammurabi and the Grecian physician Hippocrates would have been happy to see our efforts.

Doctor Burton is MSMS president.

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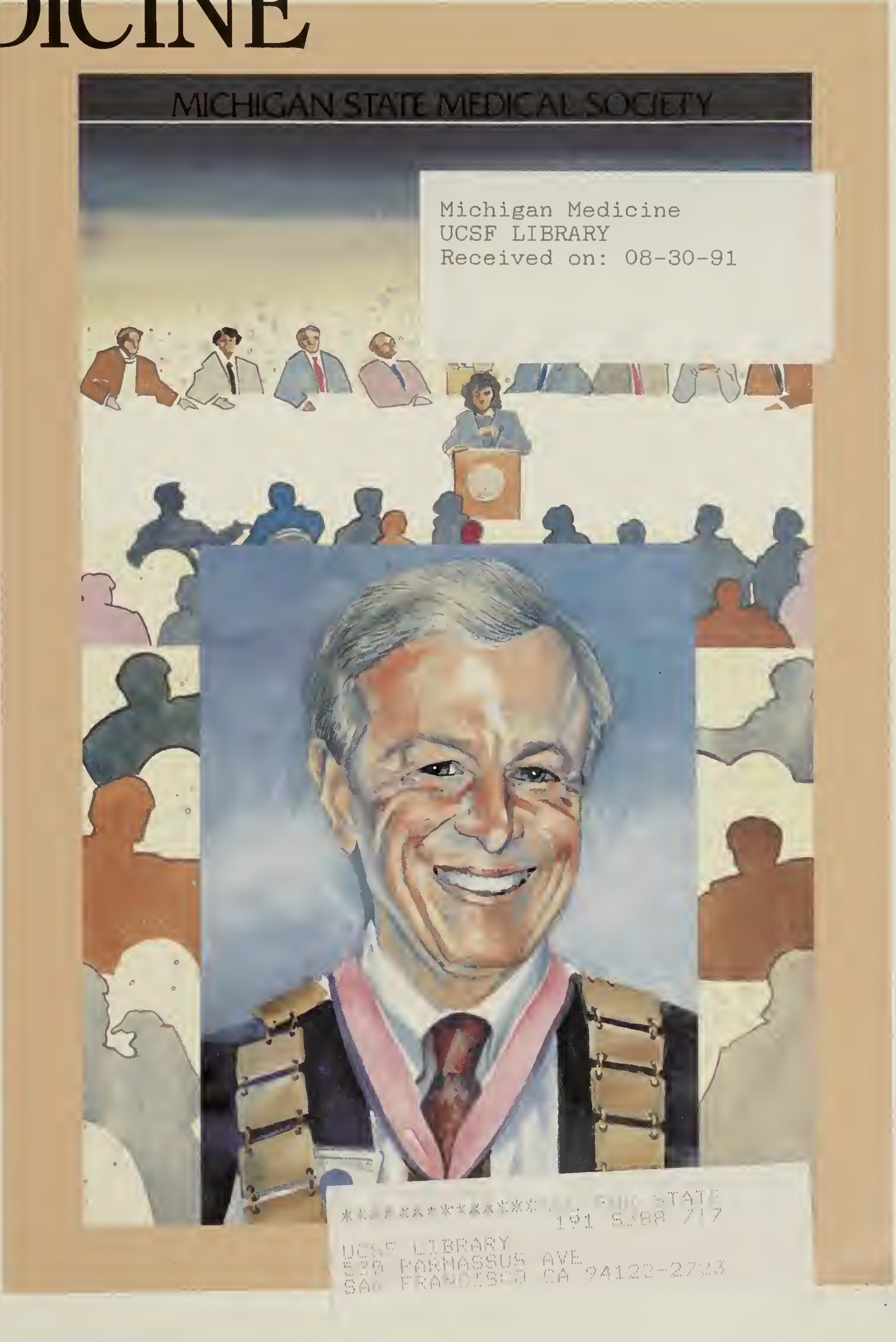

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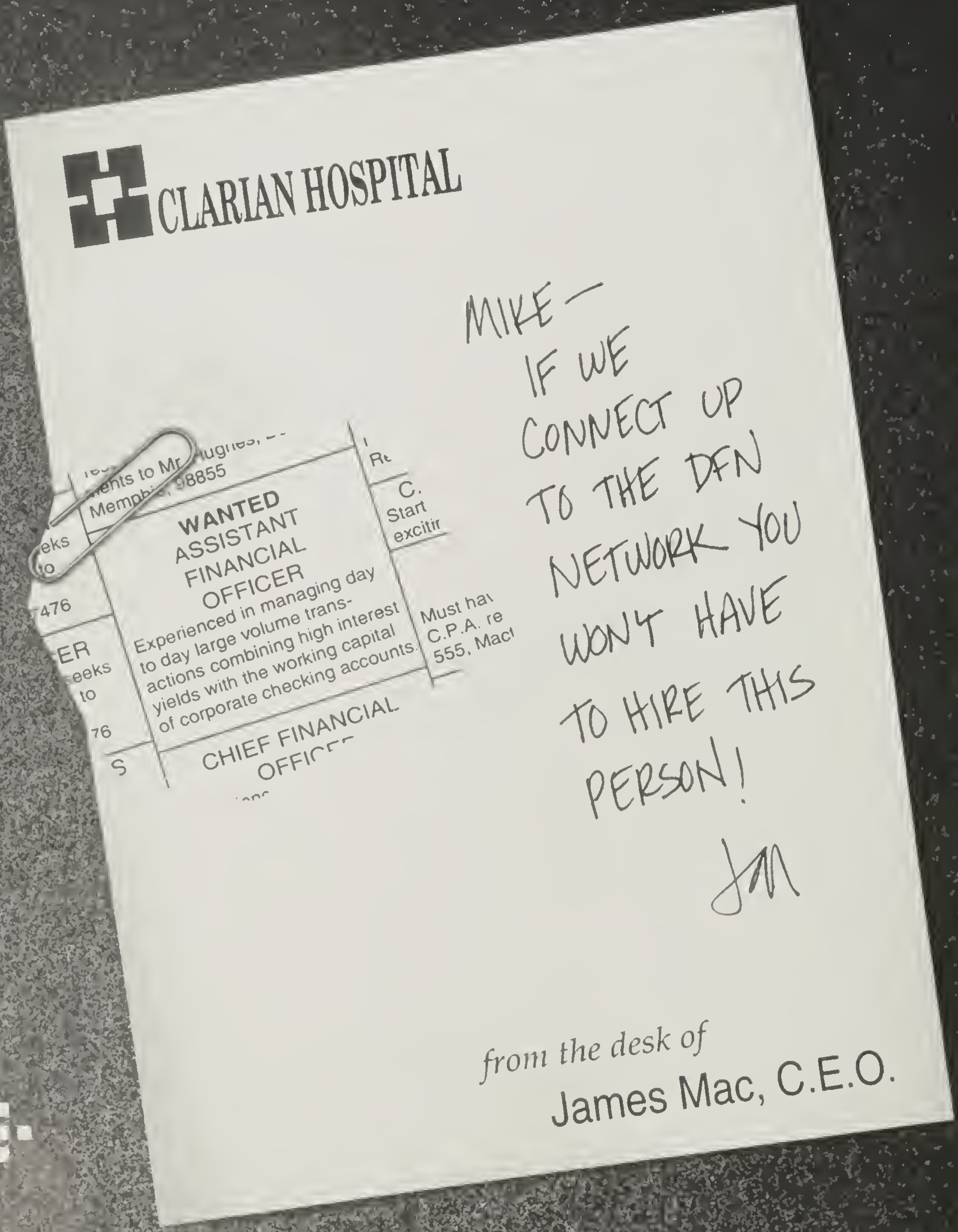

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MICHIGAN MEDICINE

DIGEST OF PROCEEDINGS

All of the proceedings of the 1991 MSMS House of Delegates meeting, plus a variety of photo highlights, are featured in this month's issue of *Michigan Medicine.* This issue serves as the official digest of proceedings. We hope you find its presentation interesting and informative. For your convenient use, please note the following arrangement of contents: Each report is followed immediately by the action of the reference committee on that report and then by the House Action on the report of the reference committee. Only resolved portions of the Resolutions appear as they were finally approved or disapproved by the House. 11

TABLE OF CONTENTS

Resolutions 12
Call to order 13
Invocation 13
Report of the Committee on Credentials and Tellers 13
Report of the Committee on Rules and Order of Business 13
Speaker's Report 13
Report of the AMA Delegation 27
Report of the Michigan State Medical Society Auxiliary 27
Report of the Physicians Review Organization Of Michigan (PROM) 27
Report of the Physician Service Group, Inc. 28
Report of the Health Education Foundation 28
Report of the MSMS Group Insurance Trust 28
Address of the President 30
Address of the President-Elect 33

PRESENTATIONS OF THE BOARD

Report of Board Activities 37

REPORTS OF HOUSE OF DELEGATES COMMITTEES

Committee on Constitution and Bylaws 43

RESOLUTIONS

House action on resolutions 45

SPECIAL MEMBERSHIPS

Life Memberships 59
Retired Memberships 59

AWARDS

Plessner Award 59
Fifty-Year Awards 59
Flag Award 60
National Presidents Award 60
Presidential Citations 60
AMA House of Delegates Certificates of Appreciation 60
ELECTIONS 61
REFERENCE COMMITTEE PERSONNEL 62
RECORD OF DELEGATES' ATTENDANCE 63

DEPARTMENTS

MSMS "On the Move" 7
Reimbursement Roundup 9
Meetings 66
Category I Courses 68
Classifieds 69
Advertising Index 71
President's Page 72
"Public health: It's everybody's business"
BY ROBERT D BURTON MD

Page 13

Page 27

CELEBRATING
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Page 45

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Women in Medicine.

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MSMS On The Move

A MONTHLY UPDATE OF KEY MSMS ACTIVITIES

Physician input critical on HCFA's proposed reimbursement plan

MSMS is urging Michigan physicians to contact their congressmen to protest the Health Care Financing Administration's (HCFA) proposed reductions in Medicare reimbursement. They would be part of the new Medicare payment system formed on a resource-based relative value scale (RBRVS) that will take effect Jan. 1, 1992. HCFA's proposed rules on the new system include reductions that would drop by 16 percent the conversion factor which changes relative value units for physicians' work into Medicare dollars. HCFA will accept comments on its proposed rules through Aug. 5, and plans to finalize the rules in October.

MSMS is working in conjunction with the AMA, which is urging that physicians around the country send their comments on the proposed rules to HCFA. In a recent mailing to all MSMS members and nonmembers, MSMS leaders outlined the elements of the conversion factor problem and provided a list of names, addresses, and telephone numbers of Michigan congressmen. For assistance in contacting your congressmen about this important issue, contact Kevin A. Kelly at MSMS.

Medicare payment reform briefing will update physicians

MSMS is conducting a leadership briefing Aug. 15 to help physicians better understand Medicare payment reform issues. Titled "Medicare Payment Reform Briefing," it will be held at the Wayne County Medical Society Headquarters in Detroit from noon to 5 p.m. Gilbert B. Bluhm, MD, Troy, chairman of the MSMS Advisory Committee on Medical Economics, will moderate the session. Guest speakers include Sandra Sherman of the AMA Health Care Finance Department and George Gerber, associate medical director of Government Programs at Blue Cross Blue Shield of Michigan. For further information, contact Mary Anne Ford at MSMS.

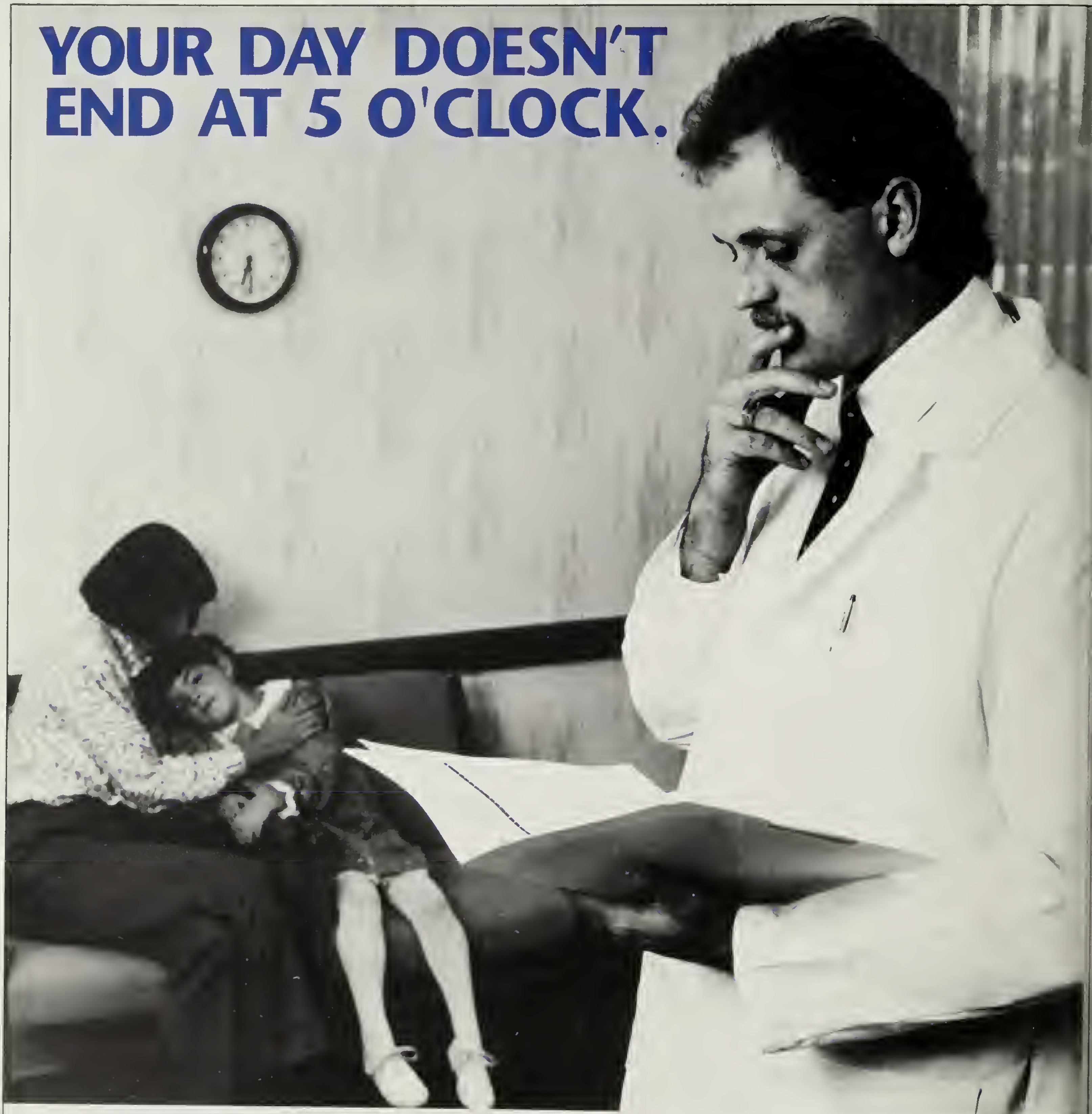
Risk management series now offers evening seminars

In response to member requests, five evening seminars have been added to the popular MSMS series "Current Issues in Risk Management." The seminars will address topics such as liability in health care marketing and advertising; the risk in consultations and referrals; medical malpractice in Michigan; and communicating adverse results. Participants will receive 3 Category I CME credits along with premium reductions based on the merit rating programs of their individual professional liability insurance carriers. The sessions will be conducted from 6:30 p.m. to 9:30 p.m. on the following dates: Sept. 10 at the Hilton Hotel in Novi; Sept. 12 at the Sheraton Hotel in Lansing; Sept. 18 at the Port Huron General Hospital in Port Huron; Sept. 24 at the Marquette Medical Dental Professional Building in Marquette; and Oct. 2 at Stouffer's Hotel in Battle Creek. For more information, contact Julie Smith at MSMS.

MSMS Board incorporates members' comments into strategic plan

MSMS surveyed delegates and alternates at the May House of Delegates meeting about potential MSMS activity in 13 different areas. The survey was part of an MSMS strategic planning process to examine its priorities. In the survey, MSMS members cited four areas they feel MSMS should focus on: professional liability, peer review organizations, physicians' image, and economics of practice. During its summer meeting July 13, the MSMS Board of Directors reviewed the survey results and planned to incorporate the suggestions into its strategic plan.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.



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REIMBURSEMENT ROUNDUP

By Rose B. Heald
MSMS Reimbursement Ombudsman

Reimbursement Roundup addresses third party payer reimbursement issues affecting physician practices. The column appears every other month in Michigan Medicine and is prepared by staff in the MSMS Department of Medical Economics and Health Care Delivery. Suggestions for topics should be forwarded to the Department.

Medicare Postpayment Audits

The search for fraud and abuse in the Medicare program has increased dramatically in the past five years, and the program is constantly looking for system offenders. As government efforts to save health care dollars escalate, the aggression of enforcement agencies becomes greater.

Common types of investigations:

Postpayment Review – Identifies possible medically unnecessary services some time after the initial claims processing; a service will be reimbursed only later to be found medically unnecessary.

Overpayment Request – HCFA requires carriers to periodically review paid claims and medical records to verify that information contained in a patient's records supports the services billed to Medicare. Discrepancies result in a request for physician repayment to the carrier.

Abuse – Physician practices, not considered fraudulent, but deemed to be inconsistent with accepted medical or business standards, such as medically unnecessary care or failure to meet professionally recognized standards of care. Examples are excessive charges for services, billing Medicare patients at a higher fee than other patients. (See list below for examples of abuse.)

Fraud – An intentional deception of the Medicare program; for example, billing for services that were never provided or billing a non-covered service as a covered service. (See list below for examples of fraud.)

Medicare investigative agents

Medicare Carrier – Majority of investigations are initiated at carrier level. Physicians should always attempt to settle a problem with the carrier and prevent referral at a higher level of review. If the carrier suspects abusive or fraudulent practices, the physician will not receive a simple overpayment request; instead all information regarding the overpayment is withheld from the physician and an investigation by the Office of the Inspector General will be initiated.

Office of the Inspector General (OIG) – Conducts investigations into suspected fraud and abuse. If a physician is the target of an OIG investigation, he/she may be the last to know... OIG investigators commonly gather all possible documentation and interview all possible parties before contacting the physician. This leads to the basic "guilty until proven innocent" assumption.

Peer Review Organizations – Responsible for ensuring that Medicare services are provided economically and only when medically necessary, and meet recognized standards of care. Before a sanction is imposed the PRO may be involved in reviewing the case with the OIG.

Actions by the Medicare carrier

HCFA requires all carriers to review at least three percent of active physicians' files each year to maintain program integrity. This does not include those physicians investigated within previous 36 months. The Michigan carrier estimates it performs 400-500 audits annually.

The carrier will identify a sample of cases in which a problem is perceived and may do so in an informal and unstructured way, as there is much carrier discretion and little HCFA guidance. The carrier can use a sampling of a physician's files rather than full case-by-case review, although there are extensive HCFA guidelines on sampling techniques. The review may be a small sampling of the physician's practice or a statistical sample for a specified time frame.

Audits may also be initiated by a complaint, or even an inquiry, from a patient or from a disgruntled employee's complaint.

Audit protocol

A physician's office must make available to the auditor the requested patient records. The government has the right to review Medicare records, as the patient's signature on the claim form or patient authorization for payment form authorizes release of all information relevant to a claim.

Auditors perform on-site reviews to compare the physician's records with the services reported on the claim form. For example, dates of services and charges billed on the claim form must be consistent with information in the medical records; procedures reported on the claim form must be supported by documentation in the physician's files. If there are discrepancies, there will be further investigation.

- Audit appointments are usually scheduled in advance;
- At time of the audit, a list of the patient records to be reviewed is provided;
- The physician has an opportunity to submit documentation for services the auditor was unable to locate during the on-site review;

Documentation is essential to survive an audit. The following documentation should be included in patient records and available for the auditor's review:

- Name of ordering/referring physician
- Accurate and sufficient documentation of service
- Verification that service was medically necessary
- Verification that service was a covered Medicare benefit
- Verification that service was properly billed

Overpayments

Records from the audit are turned over to the physician reviewers for determination of an overpayment. If that is found to be the case, the amount of overpayment is a debt owed to the US Government and

Continued on next page

Possibilities of fraud cases

- Billing for services or supplies that were not provided. This includes billing for "no shows," i.e., billing Medicare for services which were not actually furnished because the patients failed to keep their appointments
- Provider claim forms which have been altered to obtain a higher reimbursement amount
- Provider's deliberate application for duplicate reimbursement; e.g., billing both Medicare and the beneficiary for the same service, or billing both Medicare and another insurer in an attempt to get paid twice
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- False representation with respect to the nature of services rendered, charges for services rendered, identity of the person receiving the services, dates of services, etc.
- Claims for non-covered services billed as covered services, e.g., routine foot care billed as a more involved form of foot care to obtain reimbursement, or acupuncture billed as a chiropractic subluxation
- Claims involving collusion between a provider and a beneficiary, resulting in higher costs or charges to the Medicare program
- Use of another person's Medicare card in obtaining medical care
- Alteration of claims history records to generate fraudulent payments
- Repeated violations of the participation agreement, assignment agreement or MAAC limits
- Use of the adjustment payment process to generate fraudulent payments

Examples of possible abusive situations

- Excessive charges for services or supplies
- Claims for services not medically necessary, or, if medically necessary, not to the extent rendered (e.g. a battery of diagnostic tests is given where, based on the diagnosis, only a few were needed)
- Breaches of assignment agreements which result in beneficiaries being billed for amounts disallowed by the carrier on the basis that such charges exceeded the reasonable charge criteria
- Provider exceeds maximum allowable actual charge (MAAC see Chapter 3)
- Provider bills Medicare patients at a higher and different fee schedule rate than non-Medicare patients
- Improper billing practices, including submittal of bills to Medicare instead of third-party payers which are primary insurers for Medicare beneficiaries (see Chapter 5)
- Violations of Medicare participation agreements by physicians or suppliers (see Chapter 4)

Continued from previous page

must be paid by the physician, usually within 30 days, even if the carrier makes the error. The only circumstance where a physician is not liable for excess reimbursement is when his/her reasonable charge screen is incorrectly increased by the carrier and the physician had no reason to question the amount of increase.

Full appeal rights are available when the carrier requests an overpayment refund and the carrier must offer a fair hearing on overpayment within six months of request. However, the overpayment amount is due 30 days from the date of the carrier notice to the physician, regardless of the status of any appeal. If the physician does not make payment within 30 days, interest begins accruing and the overpayment amount, plus interest, is withheld from future Medicare payments.

If a physician never accepts assignment, the delinquent overpayment amount may be turned over to HCFA or the OIG for collection. Even if all of the overpayment amount is overruled in the appeals process, the physician may still be monitored for up to six months after the case is settled.

Physician safeguards

Basically, the odds are against a physician should the carrier or OIG decide to perform an audit or investigation. Physicians have been the target of an audit when they felt that they were completely ethical and forthright in their dealings with Medicare.

Physician offices should implement the following safeguards:

- **Policy Statement** – A written policy statement should be provided to all staff describing the physician's intent to be compliant with all federal program regulations and instructing staff to bring all possible violations to the physician's immediate attention.
- **Know Medicare Regulations** – Keep abreast of new Medicare regulations and make practice changes to comply with new rules. Review the fraud and abuse chapter in the new Medicare Physicians Manual.
- **Be Alert to a Possible Audit** – There are no routine follow-ups from Medicare to patients. If a patient indicates that he/she has received an inquiry from Medicare concerning services received, it may indicate the beginning of an audit. In addition, the hospital may inform the physician's office that someone has been reviewing the practice's records.
- **In the event of a possible investigation, staff should refuse any comment and refer all inquiries to the physician's attention.** The physician should refer any investigators from the OIG to his/her attorney. If contact comes from the carrier, you may also want to involve an attorney, although, in many cases, it is best to negotiate and settle directly with the carrier.
- **Be Ethical** – Don't misrepresent the facts to an investigator.
- **Conduct Periodic Reviews** – Offices should test their own internal system on a regular basis by reviewing claim forms, and medical chart documentation for all physicians.

Levels of the appeal process

- **Informal Review** – This must be submitted in writing and must include patient names, Medicare numbers, dates of service and procedures in question, why the claim should be reviewed, and additional documentation to support the review request. The request for review must be submitted within six months of the date of the remittance advice.
- **Fair Hearing** – Request for a hearing must be made within six months of the final review determination and $100 or more must be in question. The hearing offers the physician an opportunity to present a case in person before a hearing officer. The hearing officer is hired and employed by the Medicare carrier, although he/she is independent of the carrier. Regulations require that the carrier may not influence the hearing officer's decision.
- **Administrative Law Judge** – Review by an ALJ may be requested to overturn the hearing officer's decision where the amount of benefits in controversy is $500 or more. Review must be requested within 60 days of the final hearing decision. Appeal to an ALJ is available for services provided after January 1, 1987. ■

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American Medical Association

MSMS DIGEST
of Proceedings

Resolutions

Resolution **Page**

1-91A Bicycle Helmets 45
2-91A Audio/Visual Telecommunication System 45
3-91A Benzodiazepine Education 45
4-91A Benzodiazepines to Schedule II 45
5-91A Impact of State Budget Reductions 45
6-91A Child Care Availability in Hospitals 45
7-91A Equal Pay for All Physicians 45
8-91A Michigan Physicians in the Military Reserves 45
9-91A Bottle and Can Recycling 45
10-91A Curbside Recycling 45
11-91A Health Insurance for Adopted Children 45
12-91A HIV Testing After Accidental Exposure of Health Care Workers 45
13-91A Young Physicians Section (YPS) Delegate Funding 46
14-91A Elimination of Health Insurance for Pre- Existing Conditions 46
15-91A Level I Trauma Center Support 46
16-91A Toxic Waste Disposal 46
17-91A Radon Information 46
18-91A Elimination of Heavy Metals and Benzene 46
19-91A Chemical Spills 46
20-91A Per Claim Participation with BCBSM 46
21-91A Anonymity of Review 46
22-91A Proper Definition of Physician or Surgeon 46
23-91A Retired Physicians 46
24-91A Physician Call to Military Leave 46
25-91A Evaluation of Political Candidates 47
26-91A Laser Surgery 47
27-91A Consolidated Omnibus Budget Reconciliation Act Program (COBRA) 47
28-91A Michigan Peer Review Organization (MPRO) Review 47
29-91A Post-Operative Care 47
30-91A New Policies of the Michigan Board of Medicine 47
31-91A Broaden Continuing Medical Education Credits (CME's) 47
32-91A Support for the Appeal of the Determination Report on the BCBSM Medical Doctor Provider Class Plan 47
33-91A Nursing Scope of Practice 47
34-91A Identify Illustrations of Defensive Medicine 47
35-91A Mandatory Malpractice Insurance 47
36-91A Support for the Michigan Model Health Care Curriculum 47
37-91A Medical Insurance Overhead Costs 47
38-91A Public Information Campaign to Michigan Consumers 48
39-91A Shortage of Public Health and Preventive Medicine Physicians in Michigan 48
40-91A Disabled Physicians Survey 48
41-91A Equal Access for Physically Challenged Physicians 48
42-91A Who Sues 48
43-91A County Medical Care Facilties (CMCF's) Mission and Funding 48
44-91A County Medical Care Facilties (CMCF's) A State Asset 48
45-91A Funding for Regional Poison Control Centers 48
46-91A Fair and Equitable Reimbursement for Medicaid 48
47-91A Physician "Supersignature" 48
48-91A Signing Physician's Orders 48
49-91A Requirements for CME Accreditation 49
50-91A Health Care Administration Cost Cap 49
51-91A Physician Payment for Administrative Requirements Pertaining to Non-Ambulatory Home Health Care Patients 49
52-91A Environmental Concerns on Non-Reusable Materials 49
53-91A Alternative Usage of Acute Care Beds 49
54-91A Michigan Peer Review Organization (MPRO) Accept Collect Calls from Physician Offices for MPRO Medicare Pre-admission/Pre-procedure Authorization Review (PAR) Program 49
55-91A Nursing Scope of Practice 49
56-91A HMSS/MSMS Oppose the Independent Practices of Nurses 49
57-91A Change Confidentiality Rules for HIV Positive Patients 49
58-91A Reconsider Joining AMA National Credentials Verification Service 49
59-91A Control MSMS Dues 49
60-91A Physician Information on Late Reports 51
61-91A Malpractice Mediation II 51
62-91A Malpractice Mediation 51
63-91A Renew AMA International Medical Graduates' Advisory Committee 51
64-91A Payment of Physician's Services for Patients in Observational or Short Stay Units 51
65-91A Elimination of Pre-Procedural Review 51
66-91A Medical Student Section Communications 51
67-91A Physician Appointments to Health Care Committees 51
68-91A Medical Practice Standards Set by Insurance Companies 51
69-91A Rejection of Continuing Medical Education (CME) 51
70-91A Student Loan Endowment Fund 51
71-91A Subrogation Lien Rights of BCBSM in Medical Malpractice Cases 53
72-91A Opposition to Discriminatory Practices 53
73-91A Develop Michigan Externship Programs for the International Medical Graduates (IMG's) 53
74-91A Monthly Column in JAMA for International Medical Graduates (IMG's) 53
75-91A MSMS Aid to International Medical Graduates (IMG's) for Residency Placement Following Match Day 53
76-91A Residency Program Prejudiced Against Applicant with Ethnic Names 53
77-91A Study of AMA Section for International Medical Graduates (IMG's) 53
78-91A AMA to Expedite Equality in Licensure 53
79-91A MSMS Representation of Academic Physicians 53
80-91A Comparative Fee Study 53
81-91A True Peer Review 53
82-91A Medical Research Impact on the Cost of Medicare Care 55
83-91A Uniform Licensing of Physicians 55
84-91A L-glutamic Acid 55
85-91A Philip Morris Bill of Rights Tour 55
86-91A Government Mandated Fee Schedules for Automobile No-Fault Insurance 55
87-91A Workers Compensation Fee Schedule 55
88-91A Blue Cross Blue Shield of Michigan (BCBSM) Identification Cards 55
89-91A Medicare Carrier 55
90-91A Blue Cross Blue Shield of Michigan (BCBSM) Provider Class Plan 55
91-91A Blue Cross Blue Shield of Michigan (BCBSM) Claims Appeals Process 55
92-91A Repeal of PA 350 Section 401(6) and Section 502 (1)(a) and (b) 55
93-91A Medicare Intermediary 55
94-91A Divestment of Financial Holdings in Tobacco Companies 55
95-91A Medicaid Reimbursement 56
96-91A Medicaid Reimbursement as a Tax Credit 56
97-91A Medicare Durable Medical Goods Prescribing 56
98-91A PA 350 and the Mandatory Assignment Provision 56
99-91A Medicaid Reimbursement 56
100-91A Medicaid Payments to Physicians 56
101-91A Peer Review Organization (PRO) Sanctions 56
102-91A Preserving Manual Billings 56
103-91A MSMS Task Force on Access to Care 56
104-91A Do Not Resuscitate (DNR) Policy 56
105-91A HIV Testing in the Event of Accidental Exposure or Contamination 56
106-91A Opposition to a Radioactive Waste Site in Michigan 56
107-91A The Need to Enact Strict Water Quality Protection Laws for Great Lakes Water Systems 56
108-91A Indemnify Michigan Physicians Against Liability for Care of the Indigent 56
109-91A Defining the Terms "Right to Health Care" 57
110-91A Invitation to Governor Engler to Explain to Communities Why the Private Sector Should Step in Where the State is Stepping Away from Responsibility 57
111-91A Proposed Public Relations Campaign in Opposition to Medicaid and General Assistance (GA) Medical Budget Cuts 57
112-91A Removal of Michigan Doctors Political Action Committee (MDPAC) Contribution Solicitation From Dues Statements 57
113-91A Commending the Genesee County Medical Society on Its 150th Anniversary 57
114-91A Medicaid Funding for Norplant Implants 57
115-91A Therapeutic Optometic House Bill 4407 57
116-91A Administrative Services Only Regulations 57
117-91A Prescription for Androgenic Anabolic Steroids 57
118-91A Nathan Davis Award 57

Michigan State Medical Society
House of Delegates
126th Annual Session
May 3-5, 1991

Photos by Michael J. Schimpf

MICHIGAN STATE MEDICAL SOCIETY
DISTRICT FOUR
PRESIDENT

Delegates considered 118 resolutions at the 1991 MSMS House of Delegates meeting May 3-5 in Dearborn. Topics ranged from toxic waste disposal to Medicaid reimbursement.

Call to Order

The 126th Annual Session of the House of Delegates of the Michigan State Medical Society, convened at 7:30 p.m., at the Hyatt Regency, Dearborn, Speaker Robert D. Allaben, MD, and Vice-Speaker Gary D. Maynard, MD, presiding.

Invocation

The Speaker called upon Carol G. Hylkema, Moderator of the Detroit Presbytery, to give the invocation.

Report of the Committee on Credentials and Tellers

Chairman Duane E. Smith, MD, reported a quorum seated, the majority of whom were not from any one county.

Report of the Committee on Rules and Order of Business

Chairman Reed K. Freidinger, MD, reported the actions of the Committee on Rules and Order of Business as follows:

Order of Business: The Committee on Rules and Order of Business approved the Order of Business for the 1991 Annual Session as printed in the Delegates' Handbook.

Late Resolutions: Five late resolutions were presented to the Committee.

Resolution 114-91A "Medicaid Funding for Norplant Implants" submitted by Sandra Brinker, WSU, for Michael Stack, for the Medical Student Section.

Committee Recommendation: That this resolution be accepted.

Resolution 115-91A "Therapeutic Optometric House Bill 4407" submitted by Ali H. Sawaf, MD, for the Delta County Medical Society.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 116-91A "Administrative Services Only Regulations" submitted by Edwin M. Knights, MD, for the Michigan Society of Pathologists.

Committee Recommendation: That this resolution be accepted.

Resolution 117-91A "Prescription for Androgenic Anabolic Steroids" submitted by Angel Farina, MD, Wayne County.

Committee Recommendation: That this resolution be accepted.

Resolution 118-91A "Nathan Davis Award" submitted by Doctors Huldin, Margulies, Powsner, Smith and Edelmann from the Outstate Caucus.

Committee Recommendation: That this resolution be accepted.

Speakers' Report

Robert D. Burton, MD
Robert D. Allaben, MD

Here is a brief review of the progress in implementing the resolutions adopted at the 1990 Annual Session of the House of Delegates.

The House took no actions on Resolutions 5-90A, 20-90A, 33-90A, 35-90A, 39-90A, 41-90A, 45-90A, 54-90A, 63-90A, 71-90A, 75-90A, 77-90A, 86-90A, 93-90A, 96-90A, 97-90A and 112-90A. Resolutions 4-90A, 11-90A, 12-90A, 13-90A, 17-90A 28-90A, 46-90A, 48-90A, 58-90A, 68-90A, 70-90A and 74-90A were disapproved.

Resolutions

1-90A **Title: Radioactive Waste Disposal.** Substitute Resolution (in lieu of 1-90A and 2-90A). Adopted.

This resolution called upon MSMS to expeditiously review and make recommendations for an MSMS position on the disposal of low-level radioactive waste.

The issue was referred to the new MSMS Task Force on the Environment and Health, which appointed a subcommittee to develop recommendations. Efforts are underway to develop recommendations which respond to concerns about safe disposal of low- level radioactive waste with the needs of physicians who generate low-level radioactive waste as part of their patient care activities. These are complex issues, and recommendations may take some time to develop. In the meantime, MSMS continues to participate in the Michigan Department of Public Health's Low-Level Radioactive Waste Advisory Committee, which is charged with assuring appropriate public health safeguards for radioactive waste disposal sites.

2-90A **Title: In Opposition to the Low-Level Radioactive Waste Policy Act of 1980.** Substitute Resolution (in lieu of 1-90A and 2-90A). Adopted. See Resolution 1-90A.

3-90A **Title: Third Party Imbursement for Physician Services.** Substitute Resolution (in lieu of 3-90A and 25-90A). Adopted.

The resolution directs MSMS to work with interested parties to achieve a level of payment for physician services comparable to other states in the region.

Five representatives from MSMS currently participate in the Blue Cross and Blue Shield of Michigan Physician Contract Advisory Committee, which was created by BCBSM's new Physicians Participating Agreement. One of the issues identified as a priority for that Committee's work is reimbursement for physicians services. An issue slated for discussion by the Physicians Contract Advisory Committee is the Blue Cross and Blue Shield Association survey which MSMS recently obtained, showing maximum payment in Michigan to be 40 percent less than the average maximum payment in five adjacent states.

MSMS representatives to the Committee are asking BCBSM representatives to provide data to assist in further analysis of the survey and to discuss the factors that contribute to Michigan's health care costs, including liability and health status indicators. The survey was the sole subject of discussion at an April 17 meeting of the Physician Contract Advisory Committee. Plans for further activity on the survey will be discussed at the Friday evening session of the House of Delegates.

4-90A **Title: Optional Health Care Insurance Coverage for MSMS Members.** Disapproved.

5-90A **Title: Reimbursement for Medical Trauma Care Related to Drug Enforcement.** No Action.

6-90A **Title: Medical Mediation Panels.** Adopted as Amended.

This resolution asked that MSMS seek changes in the mediation process so that (1) mediation panels do not convene unless there are at least two physicians present and (2) the two physician mediators are selected through the court administrative process, rather than appointed by the respective litigants.

Legal Counsel has discussed the issues raised in this resolution with the State Bar of Michigan Medicolegal Problems Committee. He will continue to work with the State Bar to achieve these changes. In addition, he has recommended to the State Bar that medical malpractice mediation cases be scheduled on the same day so that physician mediators who have more than one case could handle them in sequence on the same day. MSMS will continue to aggressively pursue these changes in the mediation process.

7-90A **Title: National Practitioner Data Bank Implementation.** Adopted.

This resolution asked that MSMS adamantly proclaim its opposition to the implementation of the National Practitioner Data Bank.

This resolution was referred by the MSMS/HMSS Governing Council to the Michigan Delegation to the AMA for communications at the 1990 Interim meeting. The MSMS/HMSS Governing Council also presented this resolution in testimony during the AMA-HMSS Interim 1990 16th Assembly.

8-90A **Title: Nursing Home Admission Assessment. Adopted.**

This resolution asked MSMS to oppose House Bill 5363 and House Bill 5388 that would require pre- admission screening for nursing home applicants.

MSMS was successful in keeping both bills in their respective committees throughout the legislative year. Hearings were never held on this legislation.

9-90A **Title: Indemnification for Indigent Obstetrical Care.** Adopted as Amended.

This resolution asked that MSMS explore every available avenue for the indemnification of physicians providing obstetrical care to Medicaid and other indigent patients.

This year, MSMS has intensified its efforts to obtain indemnification for physicians providing obstetrical care to indigent patients. The state's "Baby Your Baby" campaign and the MSMS "43 Cents on the Dollar: the False Health Care Promise on Medicaid" campaign have been valuable in educating policymakers about the impact of the medical liability crisis on access to obstetrical services in Michigan. Efforts to address the problem were initiated with former MDPH director Raj M. Wiener, and are continuing with Vernice Davis- Anthony, the new MDPH Director. Options under consideration include a state legal expense fund, limited immunity for care provided under contract with state of local health departments, and the development of practice guidelines to protect obstetricians from liability. MSMS looks forward to working with MDPH on this important issue.

10-90A **Title: Liability Insurance Premium Renewal Notices.** Adopted as Amended.

This resolution asked that MSMS encourage the Michigan Insurance Commissioner to promulgate rules to require notification of premiums to policyholders at least 30 days prior to the renewal date for malpractice insurance policies.

The Task Force on Professional Liability met with Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) re renewal notifications to policyholders. Both companies stated that they routinely give 30 days notice including premiums to policyholders prior to renewal. In addition, both companies committed to look for ways to improve communications with their respective insureds.

11-90A **Title: BCBSM Cease Implementation of the Physician Retrospective Profiling Programming.** Disapproved.

12-90A **Title: MDPAC Board to Include Graduates of Foreign Medical Schools.** Disapproved.

13-90A **Title: Cataract Survey Pre-Certification.** Disapproved.

14-90A **Title: Automobile No-Fault Insurance.** Substitute Resolution (in lieu of 14-90A and 61-90A). Adopted.

This resolution asked that MSMS oppose the use of the Workers' Compensation Fee Schedule for automobile insurance health care services. Senate Bill 712, sponsored by Senator Dick Posthumus, required that a fee schedule be adopted for health care services in no-fault automobile insurance.

Senate Bill 712 was referred to the Senate Commerce Committee. MSMS testified on several occasions in opposition to the provision that would implement the use of the Workers' Compensation Fee Schedule in the no-fault automobile insurance system. Senate Bill 712 was never reported out of the Senate Commerce Committee.

MSMS anticipates further legislative discussions on no-fault automobile reform in early Spring. MSMS will continue to oppose the use of the workers compensation fee schedule in the no-fault automobile insurance system.

15-90A **Title: Managed Care Periodic Interim Payment Programs.** Adopted.

This resolution asked that MSMS work with major managed care companies and other third party payors to formalize a system for periodic interim payments for prenatal care.

Staff researched the issue by talking with the medical directors of several HMOs around the state and presented findings to the MSMS/BCBSM Liaison Committee. After discussion at the November 21, 1990, meeting of the Committee, a motion was adopted to refer the issue to the American College of Obstetrics and Gynecology for further action. A letter to this effect was sent by Gary D. Maynard, MD to Federico Mariona, MD, ACOG President, on November 30, 1990.

16-90A **Title: Closing of Small Community Hospitals.** Adopted.

This resolution asked MSMS to request the AMA to encourage legislation to reduce the financial constraints on small rural hospitals in order to improve the access to health care.

The Michigan Delegation to the AMA introduced a resolution to this effect at the AMA Annual Meeting in June, 1990. It was adopted.

17-90A **Title: Ophthalmology for the Lower Income Patient.** Disapproved.

18-90A **Title: Physician Testimony is the Practice of Medicine.** Referred to the Board for further study.

19-90A **Title: Adoption.** Adopted as Amended.

This resolution called on MSMS to request the AMA to support the provision of adoption information as an option to unintended pregnancies, and to request the AMA to support and encourage the counselling of women with unintended pregnancies as to the option of adoption.

The Michigan Delegation introduced this resolution at the AMA Annual Meeting in June, 1990. The resolution was adopted as reaffirming existing AMA policy.

20-90A **Title: Universal Payment Program for Birth Procedures.** No Action.

21-90A **Title: GFMS Members to International Medical Scholar Program.** Adopted.

This resolution directed MSMS to request that the AMA appoint at least one graduate of a foreign medical school to the Council of the International Medical Scholar Programs, and added that this member should keep the AMA Advisory Committee on International Medical Graduates informed of all activities.

The Michigan Delegation to the AMA carried this resolution to the AMA Annual Meeting in June 1990. There, the resolution was not adopted. Testimony was largely against it, and the AMA delegates agreed that knowledge of and experience in the US medical education system should be the primary criteria for the selection of the AMA representatives to the Scholars Program. Since, then, MSMS has learned that the Program has died due to insufficient federal funding.

22-90A **Title: Medical Reimbursement.** Adopted as Amended.

This resolution asked that MSMS continue to encourage and assist the development of voluntary assignment programs in Michigan counties.

A voluntary assignment tutorial was held by Midland County physicians and senior services staff in October 1990; eleven persons representing five county medical societies and seniors' groups participated. Four county societies have active voluntary assignment programs: Midland, Northern Michigan Counties, Emmett, Gladwin and Kalamazoo. Two counties' programs will become operational in the summer of 1991. The Kent County Medical Society is to be commended for trying again after having been rebuffed by seniors' groups.

23-90A **Title: Clean Air Inside Airplanes.** No Action.

24-90A **Title: Family Planning as a Basic Health Service.** Substitute Resolution (in lieu of 24-90A and 65-90A). Adopted.

The resolution is in support of efforts to declare family planning a basic health service, and to make funding family planning services a priority.

MSMS wrote letters and testified in support of SB 884, which would have added family planning to the list of basic health services under the Michigan Public Health Code. Unfortunately, the bill failed to pass prior to adjournment of the 1989-90 legislative session, because of some legislators' concerns about whether family planning services include abortion counselling. MSMS anticipates that the legislation will be reintroduced in 1991, and will continue its support.

25-90A **Title: Interstate Reimbursement Parity for Obstetrical Services.** Substitute Resolution (in lieu of 3-90A and 25-90A). Adopted. See Resolution 3-90A.

26-90A **Title: Michigan as Initial Participant in AMA "National Credentials Verification Service."** Adopted.

This resolution asked that Michigan be one of the initial states participating in the AMA's National Credentials Verification Service.

There have been several credentials verification services developed, including on by the Hennepin County Medical Society, St. Paul, Minnesota; the joint venture between the Maryland State Medical Association and the Maryland Hospital Association; and the one marketed by the AMA.

William Norbert Budde, PhD, Director, Survey and Data Resources, AMA, presented the NCVS at the December 14, 1990, meeting of the Western Michigan Physician Executives Organization. In preliminary discussions with vice presidents of medical affairs in Michigan, there has been strong interest in implementing a credentials verification service, and in particular in the AMA service.

An MSMS task force comprised of Gary D. Maynard, MD, Robert W. Black, MD, Robert C. Prophater, MD, Marsha Milburn, MD and Edwin Doerring, DO, (representing the Michigan Association of Osteopathic Physicians and Surgeons), met to work with the Michigan Hospital Association on the possibility of establishing a joint venture on credentialling physicians.

27-90A **Title: Conflicting Standards Between Specialty Societies and Michigan Department of Public Health (MDPH).** Adopted as Amended.

This resolution directs MSMS to arrange for specialty society input into regulations for the prevention, detection and treatment of diseases and to assure consistency between state regulations and accepted standards of national medical specialty organizations.

MSMS has adopted a new policy regarding the endorsement of practice recommendations promulgated by the Michigan Department of Public Health and other state agencies. This new policy incorporates the concepts of this resolutions, and it has been forwarded to MDPH. MSMS is also now routinely sharing information regarding new regulations, such as rules governing communicable diseases, with specialty societies, so that any inconsistencies between the regulations and practice standards can be corrected.

28-90A **Title: Establishment of Tighter Communications Between Prosecutorial and Licensing Agencies and Organized Medicine.** Disapproved.

29-90A **Title: Managing Stress as a Physician.** Adopted as Amended.

This resolution asked that MSMS develop, in cooperation with the Michigan medical schools, educational sessions directed toward medical students on management of stress, exercise and nutrition.

The MSMS Annual Scientific Meeting Planning Committee works in cooperation with the medical schools to develop courses of interest to all specialties for presentation at the Annual Scientific Meeting. These topics could be developed into courses and presented at the ASM with medical students as the specially-targeted audience. The development of such courses was discussed at the planning meeting of the Committee in March and it was decided that these topics will be included in the 1991 ASM. The Committee will develop the courses through its contacts with appropriate specialty societies and medical school department chairmen.

30-90A **Title: Alternative Methods of Medical Practice.** Adopted as Amended.

The first resolve of this resolution called for MSMS to ask the AMA to evaluate available literature and to report on alternative methods of medical practice such as acupuncture, herbal medicines, etc.

The Michigan Delegation wrote the AMA describing the MSMS delegates' directive in this area. MSMS received a response in mid-November from William T. McGivney, PhD, assistant secretary of the AMA Council on Medical Service (CMS). Doctor McGivney informed MSMS that the CMS could not take up the MSMS request at this time because of the press of other business. The Council had, he said, reviewed literature and had determined there was insufficient information to support an evaluation of acupuncture. There was even less available on herbal medicine, he reported.

The second resolved of this resolution asked that MSMS continue its opposition to House Bills 4832 and 4833 which would permit licensure of acupuncturists.

MSMS testified before the House Public Health Committee in opposition to House Bills 4832-33 that would license acupuncturists in Michigan. MSMS was successful in amending this legislation to require registration of acupuncturists. House Bills 4832-33 died in the Senate Health Policy Committee at the end of the 1990 legislative session. No comparable legislation has been introduced in 1991.

31-90A **Title: Systems for Dictated Medical Records in Emergency Departments.** Adopted.

This resolution asked that MSMS encourage hospitals to provide systems for dictated medical records in their emergency departments.

The MSMS/HMSS Governing Council Chairman has submitted a letter of recommendation to the Michigan Hospital Association Chairman and President that hospitals implement the dictation/transcription of medical records in the emergency room.

The Chairman and President of MHA have discussed the matter with several hospitals and have determined that most large hospitals provide this service. Those that do not have this service are the smaller hospitals with less active emergency departments. The President of MSMS has referred the MSMS recommendation to the MHA Council on Smaller Hospitals.

32-90A **Title: Good Samaritan Law Extended to Indigent Care.** Adopted as Amended.

This resolution directed MSMS to aggressively pursue passage of legislation to indemnify physicians against malpractice suits arising from the provision of indigent care.

MSMS is pursuing a sponsor for legislation similar to the Missouri State Legal Expense Fund under which physicians would be indemnified for malpractice awards arising from providing indigent care.

33-90A **Title: Clinical Laboratory Improvement Act of 1988.** No Action.

34-90A **Title: Physicians Professional Responsibility.** Adopted.

This resolution called on MSMS to study systems or mechanisms available for Michigan physicians to deal with interprofessional relations, patient practice issues and similar ethical values.

The MSMS Department of Communications and Professional Relations continues to provide literature and updates to assist members in dealing with such issues as physician-assisted suicide, advance directives, reimbursement inequities, liability concerns, etc. In addition, the MSMS Constitution and Bylaws stipulates that the Judicial Commission shall provide advice and render opinions on ethical issues to MSMS members and the public. Other MSMS resource entities that assist physicians are the Committee on Bioethics and Physicians Service Group.

35-90A **Title: Cardiopulmonary Resuscitation (CPR).** No Action.

36-90A **Title: On-Site Automatic Cardiac Defibrillators and Trained Personnel in Sports Arenas.** Adopted as Amended.

This resolution called for MSMS, through educational efforts, to encourage large gathering facilities to provide adequate emergency services, including the latest technical medical equipment and trained personnel, when feasible.

This resolution was referred to the MSMS Committee on Communications and Professional Relations. Committee members developed a position statement calling on large gathering facilities to provide the emergency services, disseminated the policy statement through the Physicians Communication Network. Network members, in turn, were asked to share MSMS delegates' concerns with their community leaders, including their county medical societies.

37-90A **Title: Name Change from Graduates of Foreign Medical Schools to International Medical Graduates.** Adopted.

This resolution called on MSMS to change the bylaws of the MSMS Section for Graduates of Foreign Medical Schools to the MSMS Section for International Medical Graduates. With adoption of the resolution by the House of Delegates, this change was approved on the first reading. This resolution will be presented by the Committee on Constitution and Bylaws to the 1991 House of Delegates for final consideration.

38-90A **Title: Call Me Physician.** Adopted.

This resolution called on MSMS to encourage its members to request that they be referred to as "physicians" apart from other "providers" in any contracts and documents they are asked to sign.

This resolution was referred to the MSMS Committee on Communications and Professional Relations, which decided to place a notice in Medigram reminding all members of passage of this resolution. This has been done with the January 15, 1991 issue.

39-90A **Title: Promotion of Energy Efficiency to Reduce Pollution.** No Action.

40-90A **Title: Physician Recruitment in Michigan.** Adopted as Amended.

This resolution asked MSMS to develop a research project to evaluate established practicing physician flux into and out of the state.

The Resident Physician Survey was modified this year to get more specific answers about the reasons resident physicians are leaving the state. The survey showed that 47 percent of residents do not intend to practice in Michigan. The residents that are leaving cited liability premiums (67%) and the incidence of malpractice suits (70%) as major factors in their decision to leave. A subgroup of residents leaving Michigan included 22% who had originally planned to stay but changed their minds during residency. Among, this group, liability issues were an even bigger concern, cited by 86% as a major factor in their decision to leave. Other factors included third party reimbursement (47%), family considerations (41%), practice expenses (17%) and the cost of living (11%).

The survey confirmed previous findings that indicated that liability issues continue to be a deterrent to practicing in Michigan. When asked which activities are the most important for organized medicine to undertake, 99% of residents cited liability issues and 94% cited third party reimbursement.

Future research into this area will include additional information provided by the Young Physicians Section survey and data collected by the Michigan Department of Licensing and Regulation on physician migration.

41-90A **Title: Interest on Medical Education Tax Deductible.** No Action.

42-90A **Title: MSMS Medical Liability Media Campaign.** Adopted as Amended.

This resolution called upon MSMS to mount a media campaign noting the infrequency of significant injury or death due to medical negligence.

This resolution was referred to the MSMS Committee on Communications and Professional Relations, which noted that no funds had been budgeted to carry out a separate media campaign on this specific topic. Committee members, determined, however, that messages to this effect could be incorporated in the comprehensive new MSMS liability reform campaign planned for 1991 in conjunction with the Michigan Hospital

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COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
·IYDROCODONE		X			X
)XYCODONE	XX	XX	XX	XX	XX

ank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 91 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 75; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. tern. Med.* 1980 588-96.

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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Association and the Michigan Association of Osteopathic Physicians and Surgeons. They drafted a note requesting this be done, which was sent to the MSMS Committee on State Legislation and Regulations and to the Task Force on Professional Liability.

In late February – early March, MSMS joined MHA and MAOP&S to promote a statewide campaign to have physicians, hospital administrators and the public to sign "telegrams" to their legislators urging liability reform. The campaign culminated in a joint news conference March 13 and delivery of 350 bags of telegrams to state legislators. In another effort, MSMS has supported a Wayne County Medical Society effort to air radio spots calling for reform. MSMS has taken the broadcast campaign to county societies around the state successfully soliciting their support to air the messages statewide.

43-90A **Title: Treatment of Chemical Dependency.** Substitute Resolution (in lieu of 43-90A and 69-90A). Adopted.

The resolution calls for intensified efforts toward education and treatment of chemical dependency. Specifically, the resolution asks for a compilation of information about addiction treatment centers, focusing on pregnant women and teenagers; efforts to fill gaps in the availability of treatment and coordination of physician education about the treatment of substances abuse.

The Michigan Office of Substance Abuse Services (OSAS) is compiling a list of treatment centers and resources, which will be made available to MSMS for distribution to members. MSMS supported a federal grant application submitted by OSAS and the Michigan Department of Public Health to improve services to pregnant women, and will be active in state efforts to implement this program. Physician education is a priority of the MSMS Focus Group on Chemical Dependency. Although state budget deficits may result in reductions in state funding for treatment of chemical dependency, MSMS will continue its advocacy on the importance of funding for these programs.

44-90A **Title: Child Care for Mildly Ill Children.** Adopted as Amended.

The resolution asked that MSMS seek representation on the Department of Social Services Task Force for Care of Mildly Ill Children in Child Care Centers.

Because the state Task Force had nearly concluded its work at the time of the House of Delegates, MSMS could not obtain representation. We have arranged to provide comments on recommendations of the Task Force, but Task Force work is currently in abeyance, due to state budget reductions.

45-90A **Title: Studying the Feasibility of State Medical Societies Processing Medical Licensure.** No Action.

46-90A **Title: Peer Review Organization of Michigan (PROM) Anonymity.** Disapproved.

47-90A **Title: Environmental Health Care Committee.** Adopted.

This resolution called for MSMS to appoint an environmental health committee to provide input on state and federal environmental activities.

The Task Force on Environment and Health, chaired by MSMS President Susan Hershberg Adelman, MD, held its first meeting in October. Four subcommittees are addressing the issues of radioactive waste, indoor air quality, water quality and food safety. The Task Force priorities will include physician education in these areas and input into public education programs.

The Task Force sponsored a plenary session and half day course at the 1990 Annual Scientific Meeting on environmental issues, including radon, medical waste and food safety. Task Force members provided input into development of a new Michigan Department of Natural Resources Fish Consumption Advisory, that will be released this summer. The Task Force has piqued member interest in environmental issues, resulting in request for information on recycling and in MSMS sponsorship of several public service announcements on environmental issues. With input from the Task Force, MSMS participates as a member of the Statewide Food Safety Council and is currently collecting information on hazardous waste disposal for distribution to members.

48-90A **Title: National Competency Exams for Emigrees Having Profes-**

sional Health Care Education and Training to Expedite the Obtainment of Visas and Employment. Disapproved.

49-90A **Title: Access to Medical Care for the Poor.** Adopted as Amended.

The resolution was one of two calling for state assistance in covering medical liability associated with charitable care of Medicaid patients.

As noted in the comments on Resolution 9-90A, MSMS is working with the MDPH to address the problem of liability and access to care for the poor.

50-90A **Title: Medicaid Obstetric and Pediatric Services: Michigan's Noncompliance with Federal Regulations.** Adopted as Amended.

The resolution asked that MSMS take steps to document the problem of limited access to obstetric and pediatric services for Medicaid patients, and participate in the review and revision of the Michigan Medicaid program's plan for submitting data to the federal Health Care Financing Administration, required to demonstrate compliance with OBRA 1989.

The Medicaid Liaison Committee, the Michigan Chapter of the American Academy of Pediatrics and the Michigan Chapter of the American College of Obstetricians & Gynecologists have been actively involved in advising state Medicaid officials on data collection efforts. A data collection strategy has been devised that will enable Medicaid to determine how many physicians are providing obstetric and pediatric services to Medicaid patients, and to identify shortage areas. When MSMS receives the raw data from Medicaid, we will analyze it and then work to develop a plan for improving access to these critical services.

51-90A **Title: Term of Office for AMA Positions.** Adopted.

This resolution called on MSMS to request the AMA to review the terms of office for AMA leaders, and to recommend changes to promote broadened opportunities for younger and more diverse physicians to hold leadership positions.

Robert D. Burton, MD, Chairman, Michigan Delegation to the AMA, wrote AMA Board of Trustees Chairman Joseph T. Painter, MD, expressing the MSMS Delegates' directive. Doctor Painter replied that he was asking the AMA Council on Long-Range Planning and Development "to analyze the age, tenure, and other demographic characteristics of the AMA House of Delegates; to examine policies and rules pertaining to the appointment and elective processes for the AMA Councils, including the terms and tenure; and to examine mechanisms to improve the opportunities for young physicians to serve in the AMA." He encouraged MSMS suggestions as the Council carries out its assignment.

52-90A **Title: Delay in Health Care Facility and Technology Development.** Adopted as Amended.

The resolution asked that MSMS seek changes to expedite architectural and engineering review and fire marshall approval for health care construction projects.

The MSMS Advisory Committee on Health Care Policy has learned that these delays in review and approval of construction projects are a function of local government jurisdictions. We are now working with the Michigan Hospital Association to determine where these delays are most problematic, and will approach the Michigan Department of Public Health Bureau of Health Facilities for assistance in working with these local jurisdictions.

53-90A **Title: National Practitioner Data Bank.** Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A). Adopted.

This resolution asked that MSMS request the AMA to work with Congress to eliminate the inclusion of malpractice data in the NPDB, and that the AMA be asked to seek definition of "under investigation" as used in the Health Care Quality Improvement Act of 1986.

This resolution was referred by the MSMS/HMSS Governing Council to the Michigan Delegation to the AMA for communication at the 1990 AMA Interim meeting.

54-90A **Title: A New BCBSM Contract.** No Action.

55-90A **Title: Expiration Dates on Medications.** Adopted as Amended.

This resolution asked MSMS to work with the Michigan Board of Pharmacy to require that pharmacists indicate dispensing and expiration dates on the label of all prescription drug containers.

MSMS sent a letter to the Department of Licensing and Regulation urging that pharmacists be required to place the dispensing date and expiration date on the label of all prescription drug containers. The Department replied that the dispensing date is already required to be on the label and that only the Legislature can require that the expiration date be included on the label.

56-90A **Title: BCBSM Pre-Admission Approvals.** Adopted as Amended.

This resolution asked that MSMS endeavor to prevent retrospective payment denials of pre- approved health care services delivered to BCBSM subscribers.

The issue was brought before the MSMS/BCBSM Liaison Committee for discussion at its November 21, 1990, meeting. The committee emphasized the need for BCBSM consistency when determining pre- certification and the criteria used by auditors in determining retrospective payment denials.

The Committee adopted a motion that MSMS write a letter to BCBSM requesting that the criteria be the same for pre-certifications and audits and that immediate efforts be made by BCBSM to minimize the unfair penalization of physicians in this "double jeopardy" situation. Such a letter was written to Fred R. Severyn, MD, BCBSM Vice- President and Corporate Medical Director, from Chairman Gary D. Maynard, MD, on November 28, 1990. The issue is still under study by BCBSM. The problem of inconsistency between retrospective review and pre-certification criteria has also been address in the report on the 44 BCBSM problems.

57-90A **Title: Development of a List of Physician Volunteers.** Adopted as Amended.

This resolution called on MSMS to request the AMA to explore developing a list of credentialled physician volunteers who can be available on short notice to provide help in disaster areas.

The Michigan Delegation to the AMA submitted a resolution to this effect at the AMA Interim Meeting in December 1990. It was not adopted, as the AMA delegates felt such an activity would duplicate efforts of other organizations.

58-90A **Title: Fair Fees for Chart Copying.** Disapproved.

59-90A **Title: Physician's Pharmacy Licensing Fee.** Adopted.

This resolution asked that MSMS vigorously oppose the physician pharmacy license fee in Michigan.

A letter expressing opposition to the physician pharmacy license fee was sent to the Department of Licensing and Regulation. The Department stated that the licensing fee is set by the Legislature and is intended to cover the cost of administering the provisions of the controlled substance article of the Public Health Code. This includes the licensure of prescribers and dispensers, maintenance of required records, the triplicate prescription program and the investigation of allegations of controlled substance violations.

MSMS explored with legislative staff the feasibility of repealing the physician pharmacy license fee, but was advised that it is not politically feasible in this time of extremely tight budget constraints.

60-90A **Title: Recycling and Using Recycled Paper.** Adopted as Amended.

This resolution asked that MSMS (1) recycle rather than discard paper whenever possible (2) use recycled paper to the greatest extent possible and (3) place a "recycled paper" logo at the bottom of such stationary.

MSMS has implemented a recycle program for all staff at the Headquarters building and the Stockwell building. In addition, MSMS is using recycled paper to the greatest extent possible with the "recycled" paper logo.

61-90A **Title: Automobile No-Fault.** Substitute Resolution (in lieu of 14-90A and 61-90A). See Resolution 14-90A.

62-90A **Title: Health Insurance Consultation Service.** Adopted as Amended.

This resolution presents two issues to the Physician Service Group (PSG, Inc.) Board of Directors. First, insurance consulting in the State of Michigan requires a specific license. Currently, some PSG staff are licensed agents, under the Michigan State Insurance Code are only allowed to provide information regarding insurance policies and companies they are under contract to market; while consultants must advise clients on a fee-for-service basis. The two licenses are mutually exclusive, meaning additional staff would have to be added to PSG with the appropriate consulting licenses.

The second issue this resolution presents to the PSG Board is a fundamental re-direction of PSG's goals and services to the MSMS membership. Both its long-range plans and marketing programs are focused on informing the MSMS membership of these activities. This resolution would require PSG to re-direct its efforts market the insurance consulting service to the general public. In order to do this, PSG would have to find a source of additional capital in order to begin this type of marketing program. For these reasons, the Board of Directors of PSG declined to pursue the insurance consulting services discussed in the resolution.

The second part of the resolution requests MSMS to provide general information about health insurance programs in the State of Michigan. This is being done through a brochure currently available to the MSMS membership discussing the type of questions patients should ask about their insurance program. This brochure has been well received and a large number of them have already been distributed to the general public.

63-90A **Title: Recertification of State License.** No Action.

64-90A **Title: Resident Hours.** Adopted as Amended.

This resolution asked that MSMS continue to work with the Accreditation Council for Graduate Medical Education and Residency Review Committees to develop more humane residency work hours and continue to oppose legislative regulation.

MSMS expressed its concerns on this legislation before the Senate Health Policy Committee. The Legislature did not act on SB 584 before its 1990 legislative adjournment. MSMS anticipates this legislation to be reintroduced in 1991. MSMS will continue to closely monitor this legislation.

65-90A **Title: Family Planning.** Substitute Resolution (in lieu of 24-90A and 65-90A). See Substitute Resolution 24-90A.

66-90A **Title: Opposition to Specialty Recertification Tied to State Licensure.** Adopted.

This resolution directed MSMS to oppose any proposal in which a physicians license would not be renewed because he or she has not been recertified in his or her specialty.

Legislation to require a physician to be recertified in his or her specialty was not introduced in the State Legislature during the 1990-91 legislative session. MSMS will continue to closely monitor any efforts in this area.

67-90A **Title: Care for Underserved Areas.** Adopted as Amended.

The resolution directs MSMS to monitor implementation of the Michigan Essential Health Provider Program (MEHP), which provides medical school loan repayment assistance to physicians who agree to serve in underserved areas.

MSMS participated in efforts with MDPH to prioritize geographic areas of need and in development of marketing materials about the program. Because of the severe budget constraints, the 1990-91 appropriation for the MEHP program was cut from $400,000 to $50,000. As a result, it appears that only six providers - one obstetrician, three family physicians and two certified nurse midwives will receiving funding in this fiscal year. Governor Engler's 1991-92 budget proposes to continue the $50,000 appropriation. MSMS will continue to work with MDPH in the implementation of this program.

68-90A **Title: Family Planning.** Disapproved.

69-90A **Title: Update Treatment for Substance Abuse.** Substitute Resolution (in lieu of 43-90A and 69-90A). See Substitute Resolution 43-90A.

70-90A **Title: IRS Reclassification of CME Cost.** Disapproved.

71-90A **Title: Medicaid Reimbursement.** No Action.

72-90A **Title: Opposition to Malpractice Information in the National Practitioner Data Bank.** Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A). See Substitute Resolution 53-90A.

73-90A **Title: National Practitioner Data Bank.** Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A). See Substitute Resolution 53-90A.

74-90A **Title: Certificate of Need Regulation.** Disapproved.

75-90A **Title: The Need for Adequate Time to Review the First Revision in Forty Years of the BCBSM Provider Contract.** No Action.

76-90A **Title: Clinical Care Guidelines.** Adopted as Amended.

This resolution asked that MSMS support the implementation of clinical care guidelines developed by the national medical specialty societies and that MSMS encourage its members to use these guidelines as a means of providing quality care to their patients.

MSMS has added a risk manager to its staff. The risk manager will work with the Michigan chapters of the national specialty societies to implement this resolution.

77-90A **Title: Oppose Omnibus Budget Reconciliation Act (OBRA 1989) Ruling.** No Action.

78-90A **Title: Unclaimed Bodies as Potential Tissue and Organ Donors.** Referred to Board for further action.

79-90A **Title: Discontinue Unnecessary Time Records for the Michigan Society of Pathologists.** Adopted as Amended.

This resolution called on MSMS to ask the AMA to request the Health Care Financing Administration (HCFA) to discontinue requiring quarterly time reports by pathologists in hospitals.

The Michigan Delegation to the AMA submitted a resolution to this effect at the AMA Interim Meeting. The resolution was not adopted, as testimony indicating that HCFA does not impose uniform requirements for such reports, and changing the current status might produce worse results.

80-90A **Title: Duplicate Bureaucratic Regulations.** Adopted.

This resolution asked that MSMS lend its resources to identifying duplicate regulatory activities.

MSMS is working with the Michigan Hospital Association to develop a package of bills that would provide regulatory flexibility for hospitals. The bills which are expected to be introduced in the legislature shortly, include CON reform and and reducing the number of hospital inspections by state officials.

The second and third parts of this resolution called on MSMS to request the AMA to inform government officials of duplicate regulatory activities and inspections of hospitals, in the attempt to eliminate such duplications.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1990 AMA Interim Meeting. The resolution was adopted as amended with the addition of nursing homes to those bodies being inspected. The amendments called on the American Hospital Association to help eliminate the duplications.

81-90A **Title: Excessive Medical Administrative Costs.** Adopted.

This resolution asked that MSMS and the AMA seek reduction in regulatory requirements such as record review, length of stay, insurance requirements and form completion, and diagnosis coding for physicians and hospitals, and that future regulatory requirements for physicians and hospitals not be compensated.

This resolution was referred to the Michigan Delegation to the AMA to present at the 1990 Interim Meeting. It was strongly endorsed by the AMA/HMSS Governing Council.

Parts two and three of this resolution called on MSMS to request the AMA to seek reduction in regulatory requirements for physicians and hospitals, and to oppose future requirements for which physicians and hospitals are not reimbursed.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1990 AMA Interim Meeting. The resolution was adopted.

82-90A **Title: National Practitioner Data Bank.** Adopted.

This resolution addressed objections to the use of the Data Bank for reappointments to a medical staff, and objections to mandated reappointment inquiry.

The MSMS/HMSS Governing Council determined that there is a need to clarify and communicate information on the NPDB to HMSS representatives, chiefs of medical staffs, and county society physicians, who may participate in activities which will be subject to NPDB law. The Department of Physician Hospital Relations has distributed a brochure, which will provide physicians an overview of NPDB requirements and operations instructions.

83-90A **Title: Modifications in the Arbitration Law.** Adopted as Amended.

The resolution calls for MSMS to seek several modifications in the arbitration law, aimed at modifying the physician/patient arbitration agreement.

Expanded use of the arbitration system was one of the issues considered by Governor Blanchard's factfinder on medical liability. MSMS has advocated the reforms called for in the resolutions as being valuable to expanded use of the arbitration system. Early in 1991, the MSMS Board of Directors adopted a Medical Liability Work Plan that calls for measures to expand the use of arbitration. In addition, Gerald H. Mandell, MD, has been appointed to a subcommittee of the Michigan Arbitration Advisory Committee which will begin to study and recommend changes to encourage participation in the arbitration program.

84-90A **Title: Litigation of Non-Meritorious Suits.** Adopted as Amended.

This resolution asked that MSMS request the liability insurance carriers to investigate a mechanism to supplement the insured physicians' liability policy limits in cases where the insurance company desires to litigate.

The Task Force on Professional Liability met with both Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) on this matter. Both companies agreed to work with MSMS to explore mechanisms for excess insurance such as "verdict only" insurance.

85-90A **Title: Insurance Premiums.** Adopted as Amended.

This resolution asked that MSMS request the liability insurance carriers to investigate a more equitable insurance premium structure that can vary with a physician's volume of practice.

The Task Force on Professional Liability met with both Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) on this matter. Both companies already offer significant adjustments for part- time and first-year practice and premium options based on patient volume through group programs. In addition, both companies indicated their willingness to work with MSMS to explore additional approaches to accommodate the intent of this resolution.

86-90A **Title: Adjustment of Jury Verdicts for Patients Contributory Negligence.** No Action.

87-90A **Title: Cost of Medical Waste Disposal.** Adopted as Amended.

The resolution called for MSMS to study the cost of compliance with 1989 regulations governing the disposal of medical waste, and to seek reimbursement from the state of those costs.

MSMS has been unable to obtain any reliable information of the cost for physicians of complying with the new regulations. Physician practices for disposing of medical wastes vary widely, depending on their location and type of practice. The Michigan Hospital Association hopes to have some information on the cost to facilities, and will share it with MSMS as it is completed.

88-90A **Title: Medicaid Denial Review.** Adopted as Amended.

This resolution directed MSMS to seek a change in the Medicaid threshold for initiating a 100 percent case review, by requesting a denial rate of at least five percent before 100 percent review. To date, Medicaid officials have not agreed to any changes in their policy. The Medicaid Liaison Committee will continue to raise this issue, and will also approach the Michigan Hospital Association about possible collaborative efforts.

89-90A **Title: Shortage of Nursing Home Beds.** Adopted as Amended.

The resolution called for MSMS to pursue legislative and administrative avenues to address the shortage of skilled and basic nursing home beds in Michigan.

With MSMS support, legislation to relax Michigan requirements regarding hospital "swing beds" was enacted last year. Deregulation of hospitals, anticipated with Governor Engler's interest in repealing CON requirements, should further alleviate the problem. Current CON law requires that MDPH convene expert committees to develop CON criteria and MSMS will offer its expertise to committees established to discuss long term and nursing care needs.

90-90A **Title: Directory of Graduate Medical Education Programs.** Adopted as Amended.

Parts one and two of this resolution directed MSMS to encourage the AMA to continue to provide the Directory of Graduate Medical Education Programs (DGMEP) to medical students until transition was complete to the new AMA Fellowship and Residency Electronic and Interactive Database Access (FREIDA) system, and for MSMS to encourage the AMA to make the FREIDA system compatible with Apple Macintosh computers.

The Michigan Delegation to the AMA wrote M. Roy Schwarz, MD, AMA assistant executive vice president, expressing the MSMS House directive. To date, no formal response has been received by MSMS to this letter. However, MSMS has learned from the AMA Department of Data Systems that the AMA indeed is supplying medical students with copies of the DGMEP until the FREIDA system is on line, which is expected in February or March. Also the Department of Data Systems assures MSMS that the new system will be compatible with Apple Macintosh computers.

This resolution requested MSMS to research the feasibility of obtaining the AMA-FREIDA system for distribution to medical students as a membership incentive.

MSMS has learned that the AMA-FREIDA system, the electronic interactive database for residency programs is in its first year of operation and only 70% of all residency programs are listed in the system.

The system has been purchased by each medical school in the state and by the following hospitals: Henry Ford Hospital; Mt. Carmel Hospital; Mercy-St. Joseph Hospital; Providence Hospital; St. John's Hospital; and William Beaumont Hospital. The MSMS Medical Student Section has purchased the actual Directory of Graduate Medical Education Programs for reference use. The information will be disseminated to the third and fourth year medical students for their use.

91-90A **Title: Immunization and Preventative Health Care for Children.** Adopted as Amended.

The resolution asks MSMS to seek legislation requiring insurance coverage for preventative health care visits and immunization for all children.

With health care cost containment as a major legislative concern, achievement of this resolution may not be politically feasible.

92-90A **Title: Endorsement of a Living Will.** Adopted as Amended.

The first part of this resolution called on MSMS to make available to members the Genesee County Medical Society's format for a living will/durable power of attorney document.

This resolution was referred to the MSMS Department of Communications and Professional Relations. The Department devoted the December, 1990, Michigan Medicine cover story to the living will issue. The magazine included a copy of the Genesee County living will perforated for easy removal and photocopying by MSMS members' offices.

Also, as of this writing, a Durable Power of Attorney document developed by a coalition consisting of MSMS, State Bar of Michigan, Michigan Hospital Association, and Michigan Association of Osteopathic Physicians and Surgeons will be bound in the April 1991, issue of

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Michigan Medicine. In addition, plans are underway to make this document available to the public and to institute an extensive campaign urging all citizens to execute a Durable Power of Attorney.

The second portion of the resolution directed MSMS to work for passage of living will/Durable Power of Attorney legislation by the Michigan Legislature.

MSMS was successful in the passage of House Bill 4016, sponsored by Representative David Hollister that would allow for the use of Durable Power of Attorney to make medical treatment decisions for patients unable to do so on their own behalf. MSMS also actively supported House Bill 4176, sponsored by Representative Perry Bullard, that would allow the use of living wills in Michigan. House Bill 417 did not pass during the 1990 legislative session.

MSMS is currently working on the development of physician/patient brochures for use in physician offices explaining how the new law works.

93-90A **Title: Initiative to Clarify State and Federal Regulations Which Affect Michigan Physicians.** No Action.

94-90A **Title: Forward Planning for Medicine.** Adopted.

This resolution called for the creation of a standing committee to look at possible responses to possible changes in medicine three years or more in the future.

A Strategic Planning Committee was appointed by Board Chairman Jack L. Barry, MD, immediately after this resolution was passed. The Committee has met twice with planning consultants and plans to meet two more times before developing a final strategic plan in mid-June. The Committee will continue to function on a periodic schedule as needed.

A second portion of the resolution called for MSMS asking the AMA to develop such a committee. An AMA planning committee already exists, so this portion of the resolution is moot.

95-90A **Title: Needs of Dementia Patients in Michigan.** Adopted as Amended.

The resolution supports efforts to fund programs aimed at meeting the needs of dementia patients and their families.

MSMS was successful in efforts to obtain funding for dementia programs in the budget adopted by the Legislature before the November elections. However, because of the state budget deficit, funding for the Dementia Program was cut by $50,000. MSMS will continue to support additional funds for the Dementia Program.

96-90A **Title: GFMS Participation in Organized Medicine.** No Action.

97-90A **Title: Filling of Available Residency Spots.** No Action.

98-90A **Title: Foreign Medical Graduate Examination in Medical Sciences (FMGEMS) Scores Not Sole Criteria for Residency Selection.** Adopted.

This resolution called on MSMS to work with the AMA to recommend that residency programs consider all the candidates' attributes and qualifications during the residency selection process, rather than use GMGEMS scores as sole criteria when reviewing candidates who are foreign-trained.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1990 AMA Annual Meeting. The AMA delegates approved this resolution.

99-90A **Title: GFMS Representation on Residency Selection Committees.** Adopted as Amended.

This resolution called for the Michigan Delegation to the AMA to ask the AMA to recommend to the Accreditation Council of Graduate Medical Education and its Residency Review Committees that they encourage appropriate representation by international medical graduates on the selection committees.

The Michigan Delegation submitted such a resolution to the 1990 AMA Annual Meeting. The AMA House did not adopt the resolution.

100-90A **Title: Inclusion of Residency Interview Costs in the Financial Aid of Fourth Year Medical Students.** Adopted as Amended.

This resolution directed MSMS to ask the AMA to work with the US Department of Education to reverse policy and to allow students to use TITLE IV (loan) funds to meet the expenses of residency interviews. If this policy could not be reversed, MSMS was to request the AMA to seek legislation so that costs for residency interviews could be covered by financial aid.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1990 AMA Annual Meeting. The AMA House of Delegates adopted this resolution in substitution form, noting that this also was the goal of the Association of American Medical Colleges and a major national association of financial aid advisors.

101-90A **Title: Sharing the Financial and Manpower Burden of the Human Genome Project with Other Nations.** Adopted as Amended.

This resolution called for MSMS to request the AMA to seek methods of encouraging industrialized nations interested in the Human Genome Project to coordinate international research efforts and to help develop a data bank.

Robert D. Burton, MD, Chairman, Michigan Delegation, wrote the AMA to transmit MSMS delegates' wishes. R. Mark Evans, PhD, director, AMA Department of Biotechnology and Molecular Medicine, responded that the AMA already had written appropriate organizations to encourage worldwide support of the Project and free and open sharing of information.

102-90A **Title: Medical School Financial Aid Reforms.** Adopted.

This resolution called on MSMS to request that the AMA clarify medical students' actual financial needs based on the true costs of medical education, and to seek increases in medical students' borrowing limits, as well as a sliding rate of interest for them.

The Michigan Delegation submitted a resolution to this effect a the 1990 AMA Annual Meeting. The AMA House of Delegates passed the resolution in substitute form.

103-90A **Title: GFMS Section Representation for Resident Physicians.** Adopted.

This resolution called on MSMS to change the bylaws of its Section for International Medical Graduates to allow for election of two delegates to the IMG Section from the MSMS Section for Resident Physicians Section. The two are to be international medical graduates, and would be elected annually.

As the MSMS House of Delegates adopted this resolution, the Section made the bylaws change. The IMG Section has written the Resident Physician Section, inviting the attendance of delegates at the 1991 IMG Section Annual Meeting. The Resident Physician Section has named one delegate.

104-90A **Title: MSMS Involvement in Workers' Compensation.** Substitute Resolution (in lieu of 104-90A and 106-90A). Adopted.

The resolution directs MSMS to assure continued input into the rules and fee schedule governing health services to injured workers.

A first set of revisions to the works compensation fee schedule and rules are being presented to the Legislature for approval. The changes reflect significant input by MSMS members for the Department of Labor's Advisory Committee on Workers Compensation Health Services Rules. The changes include updates in fees for all services, procedural changes affecting timely payment of claims and improvements in the rules affecting specific specialties. This is an ongoing activity, and MSMS will continue to play a role in future modifications to the rules. MSMS anticipates work to begin for further revisions in the Spring of 1991.

105-90A **Title: GFMS Section Representation for Non-Hospital Affiliated Physicians.** Adopted.

This resolution called on MSMS to amend its bylaws to allow for a special election of at-large delegates to the MSMS Section for Graduates of Foreign Medical Schools, to represent international medical graduates who are not hospital-affiliated.

As the MSMS House of Delegates adopted this resolution, the Section made the bylaws change. Since then, the Section has written all county medical societies asking for names of non-hospital affiliated international medical graduates. These persons then were polled for interest in serving as delegates to the Section. Those who express interest will be placed on a ballot for election at the 1991 Section Annual Meeting. Erlinda Mercado, MD, Rochester psychologists, was elected to the at-large position.

106-90A **Title: MSMS Increased Involvement in Workmen's Compensation Fee Schedules.** Substitute Resolution (in lieu of 104-90A and 106-90A). See Substitute Resolution 104-90A.

107-90A **Title: Eliminate Worker's Compensation Medical Fee Schedule.** Not Accepted as a Late Resolution.

108-90A **Title: Eliminate the Use of Government Mandated Medical Fee Schedules.** Not Accepted as a Late Resolution.

109-90A **Title: Legislation re BCBSM Health Insurance Programs.** Not Accepted as a Late Resolution.

110-90A **Title: Legislation to Guarantee the BCBSM Gives Physicians Due Process.** Not Accepted as a Late Resolution.

111-90A **Title: Audit of BCBSM.** Not Accepted as a Late Resolution.

112-90A **Title: Commercial Advertising by Trial Attorneys that Heightens the Liability Crisis in Michigan.** No Action.

113-90A **Title: Encourage Showing of the Auxiliary Medical Liability Videotape.** Adopted.

This resolution asked that MSMS encourage county medical societies to unite in regional coalitions, and enlist the support of area hospitals so that they may approach local media in an attempt to gain publicity for the material included in the malpractice videotape and other information related to the medical malpractice crisis.

The MSMS/HMSS Governing Council arranged that this videotape be shown to each of the Michigan Hospital Association districts, where it was presented by a member of the MSMS Board of Directors or a community physician. The videotape is one of the MSMS/Hospital Medical Staff Section Physician Issues presentation-III menu items.

Since the passage of this resolution, members of the MSMS Auxiliary, accompanied by an MSMS member, have shown this video to more than three dozen service clubs across the state. Several county societies including Kent, Wayne and Sanilac have used the video on media talk shows. The video will continue to be used throughout 1991 to educate the public about the continuing medical liability crisis. A strategy for increasing showings is under development between MSMS and the MSMS-A. That strategy will include getting the information in front of more media outlets this year.

114-90A **Title: Support of Charles C. Vincent, MD.** Adopted as Amended.

This resolution affirmed the MSMS House of Delegates strong support for Charles C. Vincent, MD, campaign for United States House of Representatives. It should be noted that the MDPAC Board of Directors recommended to the American Medical Political Action Committee maximum support for Charles C. Vincent, MD, Campaign for Congress. Doctor Vincent was unsuccessful in his bid for Congress but has made it known that he is considering running for Congress in 1992.

115-90A **Title: Surgical Assistants.** Adopted.

This first part of this resolution asked that MSMS recognize the vital role of surgical assistants and that MSMS seek proper recognition of surgical assistants in the Medicare program.

MSMS has worked with the AMA bringing to the attention of Health Care Financing Administration (HCFA) and Medicare administrators the vital role that surgical assistants play in the delivery of quaity medical care.

The third part of this resolution called on MSMS to request the AMA to oppose Medicare mandates that physicians must reimburse surgical assistants from the physicians' own reimbursement fees.

The Michigan Delegation to the AMA submitted such a resolution to the 1990 AMA Interim Meeting, but later withdrew it as the AMA had similar existing policy.

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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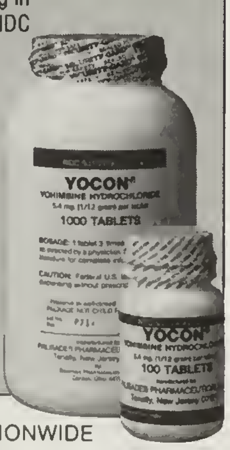

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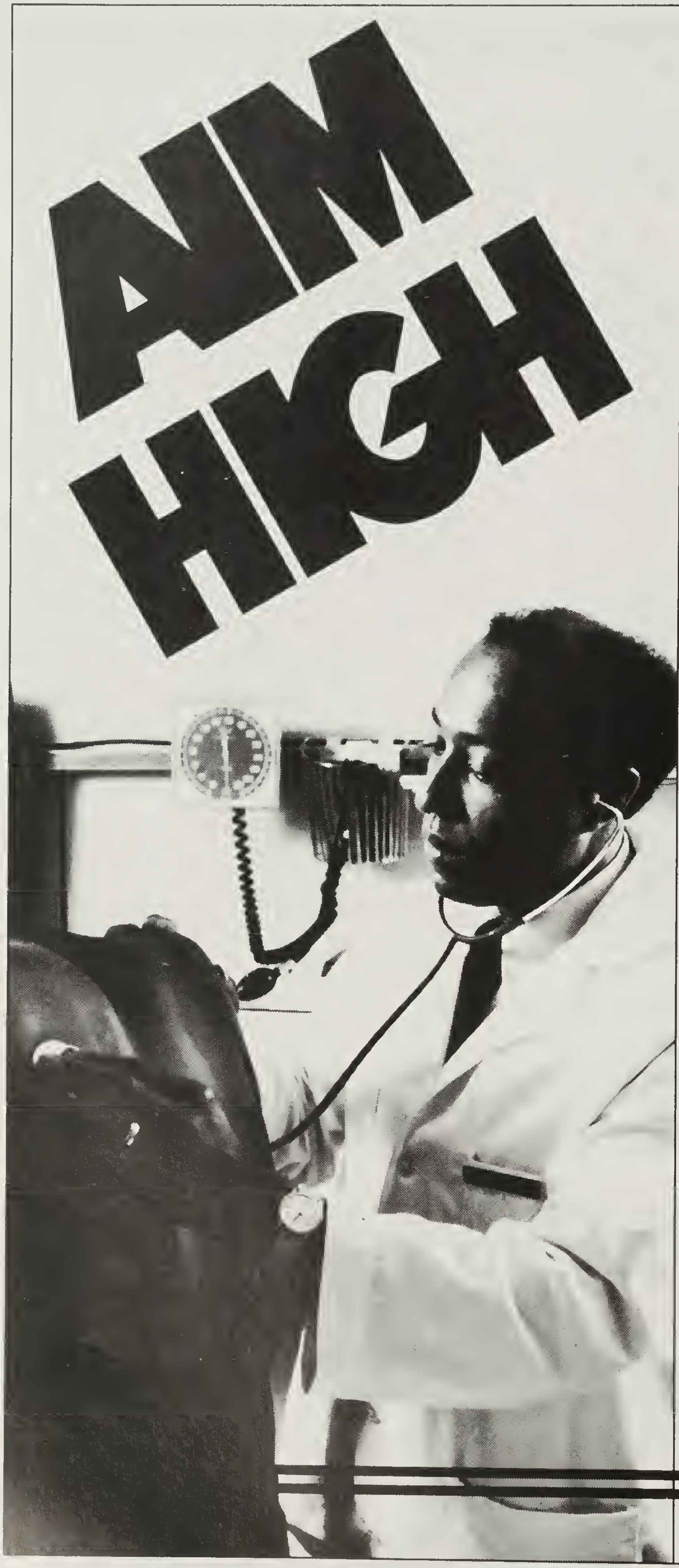

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AIR FORCE

Report of the Michigan Delegation to the American Medical Association — Robert D. Burton, MD, Chairman

Highlights of the past year for the 24-member Michigan Delegation to the AMA were the AMA Annual Meeting June 24-28, 1990 in Chicago, and the AMA Interim Meeting December 2-5, 1990 in Orlando, Florida.

At the June meeting, delegates were pleased with the election of Peter A. Duhamel, MD, as vice chairman of the AMA Hospital Medical Staff Section. Our delegation celebrated the election of Michigan Alternate Delegate Susan H. Adelman, MD, as chairman-elect of the AMA Surgical Caucus, and the election of Cathie Martin, Traverse City, to the AMA Auxiliary Board of Directors. The June meeting featured strong messages by AMA leadership about new directions for the organization following the transition between executive vice presidents.

The Michigan Delegation introduced nine resolutions at the June meeting. Three of the nine Michigan resolutions were adopted outright. Two, originated by the MSMS Section for Graduates of Foreign Medical Schools, called for the AMA to encourage legislation to reduce the financial restraints on small rural hospitals, and for the AMA to urge that FMGEMS scores not be used as the sole criterion for acceptance into residency programs. The AMA reaffirmed existing policy by adopting a Michigan resolution calling for counseling and dissemination of information on adoption as an option in unintended pregnancies. Two resolutions originated by the MSMS Medical Student Section were combined and passed with resolutions from other states. They called for the AMA to take all possible steps to reverse current federal interpretations of law so that medical students again are allowed to use Title IV aid; for increase in the annual borrowing limits on Stafford loan programs, and for a sliding rate of interest on the accumulated debt obtained through these programs. MSMS member Francis Horvath, MD, Lansing, successfully saw his call for repeal of religious exemptions in child abuse and medical practice statutes adopted as AMA policy. A Michigan resolution that the AMA work to eliminate inclusion of malpractice data in the National Practitioner Data Bank was referred to the AMA Board.

At the December meeting the Michigan Delegation introduced 11 resolutions, six of which were adopted. The Delegation applauded appointment of Alternate Delegate Rhoda M. Powsner, MD, as chairperson of the AMA House of Delegates Women's Caucus. Three Michigan resolutions were adopted outright. One called for AMA adoption of the policy that prayer should not delay access to traditional medical care, another called for the AMA to oppose any future uncompensated regulatory requirements for physicians and hospitals, and the third called for the AMA to oppose Medicare comparability and to identify Medicare access and quality problems in affected states. A resolution on AMA identification of overlap and duplication in government agency regulation of hospitals passed with amendments. Two resolutions, one calling for the AMA to work with the Accreditation Council for Graduate Medical Education on more humane residency work hours and another calling for the AMA to invite the National Center for Health Statistics ICD-9-CM co-chairperson to attend CPT-4 Task Force meetings and for CPT-4 Task Force representatives to attend ICD-9-CM Coordination and Maintenance Committee meetings, were adopted in substitute form.

Members of the Michigan Delegation to the AMA are:

Delegates: Busharat Ahmad, MD, Marquette; Robert D. Allaben, MD, Detroit; Billy B. Baumann, MD, Pontiac; Robert D. Burton, MD; Donald K. Crandall, MD, Muskegon; Gerald H. Mandell, MD, Detroit; Robert E. Paxton, MD, Fremont; Thomas C. Payne, MD, East Lansing; Richard R. Rapport, MD, Flint; Louis R. Zako, MD, and Karen Vanderwall, Inkster (student).

Alternate delegates, (in order of seniority): Robert S. Black, MD, Detroit; R. Jack Chase, MD, Grand Rapids; Rhoda M. Powsner, MD, Detroit; Susan H. Adelman, MD, Southfield; Cathy O. Blight, MD, Flint; B. David Wilson, MD, Kalamazoo; Peter A. Duhamel, MD, Rochester; Willard S. Stawski, MD, Grand Rapids; Charles C. Vincent, MD, Detroit; Marguerite R. Shearer, MD; John W. Hall, MD, Petoskey, and Brian F. Jewell, MD, Ferndale (resident).

Report of the Michigan State Medical Society Auxiliary — Patricia Dolan, President

This has been a truly rewarding year. Travel throughout the state provided opportunity to visit county auxiliaries where some friendships were renewed, new friendships were made and much information about the county, state and national auxiliaries was shared.

The Legislative Committee took an idea from another state which was presented to it and, with assistance from the MSMS Government Affairs staff, developed a "Day With A Doctor" program for Michigan. The program will be initiated by several counties this spring and summer and is designed to give legislators a first-hand look at the nature and complexity of health care delivery in Michigan. The legislator will be encouraged to spend an entire day as the physician's guest including hospital rounds, meetings and patient visits in the office. In order for physicians and lawmakers to communicate well with each other they first need to establish a common understanding of the complexities and problems in providing quality health care. MSMSA hopes to establish this ongoing legislative project in conjunction with MSMS, sponsored and administered jointly by both our Legislation Committees.

The Video Distribution Committee has continued to promote the showing of the "Medicine in Jeopardy" video to community groups across the state. With the start of a new legislative session, efforts are being renewed to bring attention to the matter. County auxiliaries assisted with the telegram campaign in mid March, helping to collect signatures and distribute the mailbags to the legislators in Lansing.

The Health Projects Committee has continued its focus on drug awareness and drug abuse prevention. The AMA/ABA project was implemented in several counties in cooperation with the county medical society and local bar association. A March workshop featured Project DARE, a drug awareness project taken into schools by local police officers, a video and posters on Bicycle Helmet Safety and World Medical Relief, the collection of unused drugs and medical equipment for use by those in need of both at home and abroad. The ACOG Teen Pregnancy posters are also being distributed.

With assistance from MSMS, a new accounting system was introduced as well as direct dues billing. Several counties participated in the initial pilot of the billing system. While refinements were necessary, initial success can be measured by the fact that other counties are requesting the opportunity to be added to the list of those presently using the new system. Similar to MSMS, opportunity is given for a contribution to MDPAC. It is hoped this will generate additional funds.

Membership has declined and the Auxiliary is in jeopardy of losing one or more delegates to the AMA Auxiliary. Much effort has been placed on retention as well as recruitment. Attempts are being made to interest resident physician and medical student spouses since they are the future of the organization, be it in Michigan or elsewhere. Identification of MSMS delegates whose spouses are AMA Auxiliary members will be made this year. The goal is to have this identification on *all* appropriate badges in the future.

The AMA-ERF Committee launched a new program this year with the introduction of recycled stationery. This project not only raises funds for AMA-ERF but helps raise the consciousness of individuals recycling and environmental concerns. The Holiday Sharing Card became a joint MSMS/MSMSA project this year and was most successful. To date, over $26,000 has been donated with much of it benefiting the medical schools in this state.

Auxiliary members have served on a variety of MSMS committees. The school education portion of the Focus Group on Chemical Dependency is chaired by an auxilian. Projects such as "Day With A Doctor," AMA/ABA drug awareness, Holiday Sharing Card, and Doctors' Day recognition have been joint efforts of the MSMS and the Auxiliary. Thanks to efforts on part MSMS and Auxiliary leaders, the current MSMS leaders, and most especially to MSMS Executive Director William Madigan and his capable staff, the partnership is not only alive and well, but actually thriving. The Michigan State Medical Society Auxiliary looks forward to continuing this relationship in the future.

Report of the Physician's Review Organization of Michigan, Inc. — Robert C. Prophater, Sr., MD, President

The year 1990 was one of struggle for PROM. PROM saw a significant decrease in its revenue due to changes in the market for its products. The organization lost approximately $42,000 in 1990. This loss was covered by the corporate reserves of the organization and did not require outside financial assistance.

During the year, the PROM Board of Directors have worked very hard to remedy the problems caused by the financial downturn. PROM continues to provide a valuable service to the physicians of Michigan; and, therefore, the Board believes it deserves a chance to revitalize the organization. The major reason for the decline can be attributed to the fact that PROM receives the majority of its revenue from a single customer, Blue Cross Blue Shield of Michigan (BCBSM). During 1990, (BCBS) changed the type and method of review, both in the hospital and for the physician. BCBS's focus has changed from inpatient medical/surgical review to other areas, such as long term care; and, most significantly, behavioral medicine review. PROM has found review in the area of behavioral medicine is extremely difficult.

Along with the shift in focus, the number of cases which BCBS has provided for review decreased significantly in the first two quarters of 1990. Since that time, while the increase in volume has not been significant, it has remained constant; and, PROM was able to adjust its expenses to reflect this new revenue base.

An important development in 1990 has been PROM's increased involvement in the area of credentialing and privileging issues among hospital staffs. While PROM has not actively sought this market, it continues to be contacted by hospital staffs seeking an organization to provide quality of care review in regards to the privileging of staff members. The PROM Board believes this is the area of significant growth in the next few years. Issues of privileging and credentialing at the hospital staff level will increasingly need a neutral organization to provide review of quality of care.

While PROM is struggling financially, the Board is of the opinion that the purpose of the corporation is to continue serving physicians and provide for the review of quality and necessity of medical care. The Board of Directors feels without the existence of PROM many physicians would have experienced extreme frustration with external review of their medical practice. PROM's continued existence is necessary as more organizations seek to evaluate the physician's practice patterns. Additionally, as the pressure on medical staffs concerning credentialing and privileging continues to increase, PROM will make itself available to assist the medical staffs. Moreover, the PROM Board has sought additional resources for the organization in order to build a broader financial base, with the goal of reversing its current financial situation.

Members of the PROM Board include: Robert W. Black, MD; Edwin Doehring, DO; Andrew J. Hogan, PhD; William E. Madigan; Marsha Milburn, MD; Robert C. Packer, MD; Richard L. Rapport, MD; Donald C. Smith, MD; Willard Stawski, MD; Floyd C. Stevens, DO; and William Stevenson.

Report of the Physician Service Group, Inc. — Billy Ben Baumann, MD, President

The Physician Service Group, Inc. (PSG) continues to be a thriving subsidiary of the Michigan State Medical Society.

1991 gross revenues were approximately $1.2 million. In addition to making its debt retirement payments and paying interest on the loans from MSMS, PSG paid a dividend to MSMS of $115,000. More important than the financial aspects of PSG, the corporation has served a large number of MSMS members with products and services of the highest quality. This is evident by the increased number of physicians currently using the PSG programs, as well as the large number of physicians who continue to seek assistance from PSG.

PSG's revenues are generated from four different areas. The first of these areas is the administrative services. This area of PSG provides management of specialty societies and other associated organizations. Currently, there are 12 organizations managed by PSG. A significant contribution PSG is making is linking MSMS and the specialty societies. During 1990, two specialty societies expanded the PSG services to lobbying and liaison activities with third party carriers. These services are provided with the assistance of the MSMS staff. PSG believes by integrating the efforts of the specialty societies with the Michigan State Medical Society, the efforts of both organizations can be multiplied.

The second area of PSG's activity is in endorsed services. Currently, PSG endorses several organizations it believes provide the highest quality services to MSMS members. The endorsements enable physicians to look to their association for products which, in the opinion of the PSG Board, are of the highest quality. In addition to the endorsed services, PSG continues to provide practice management and numerous other services focused on the needs of physicians in their practice. PSG's long term goal is to be the organization providing physicians with the goods and services necessary for them to prosper in the next decade.

Educational activities is the third area of PSG involvement. In 1990, PSG presented over 60 seminars on such topics as financial control of your practice, coding seminars, as well as numerous other seminars designed to assist both the physicians and their employees. At the end of 1990, this program was transferred to the Michigan State Medical Society in order to combine it with MSMS's current efforts in clinical and issue education. This transfer will make for a more efficient and focused educational program for all members of MSMS.

The fourth area PSG provides services in is administration of the member sponsored insurance programs. Through a contract with the MSMS Group Insurance Trust, PSG provides the customer service, staffing, and marketing for the MSMS health and dental programs. PSG staff deals with a significant number of members to resolve problems and market the MSMS insurance programs. In the coming year, this area of PSG will be involved with the marketing of the recently endorsed long term care program as well as several other activities assisting physicians in their practices.

PSG continues to make a significant financial contribution to MSMS. In addition, the PSG Board strongly believes the goods and services it provides will be of major assistance to MSMS members.

Members of the PSG Board include: Frederick W. Bryant, MD; Mark Campbell, MD; Henry Domzalski, MD; Elizabeth A. Hutchinson, MD; Mark Kolins, MD; William E. Madigan; John A. Richards; and Allen F. Turcke, MD.

Report of the Health Education Foundation — Robert E. Paxton, MD, President

The Board of Trustees met January 10, 1990; April 25, 1990; January 9, 1991; April 9, 1991. The Board meets on a quarterly basis.

The Health Education Foundation continued to work in 1990 towards its goal of increasing physician understanding of its mission through raising awareness of its activities. The Foundation has established ongoing fundraising activities and continues to receive and consider grant requests.

The Foundation is interested in all projects that are focused on health education and research. This includes programs on medical ethics, bioethics, and other such efforts. The following grants have been awarded in 1990 to: Western Michigan University, program support for Conference on Aging; Richmond Lenox Ambulance Authority, support for emergency response training program; Council of Michigan Foundations, support for annual meeting held in Lansing; Bruce Fund, annual gift to University of Michigan Pediatric Department; Michigan Health Council, annual support.

In 1990, the Health Education Foundation provisionally accepted the fiscal responsibility of the Michigan Chapter, American College of Surgeons Danto Memorial Cancer Fund. This $18,000 fund provides a monetary award for the best Cancer Paper during the annual Coller competition.

The Health Education Foundation appreciates the support provided by MSMS, both financially and organizationally. The Foundation plans, in 1991, to continue to work to increase contributions enabling the Foundation to proceed with its mission of providing grants to advance the field of health for the public good within the State of Michigan.

Members of the Board of Trustees include: Bruce W. Ambrose; Richard M. Campau; Mrs. Nancy Crandall; Henry M. Domzalski, MD; William E. Madigan; Richard J. McMurray, MD; Robert E. Paxton, MD; Suzanne H. Pederson; Arthur L. Tuuri, MD; Rev. Bertram W. Vermeulen; Mr. Richard D. Weber; Louis R. Zako, MD.

Report of the MSMS Group Insurance Trust — B. David Wilson, MD, Chairman

As the administrators of MSMS's sponsored health, dental, disability, term life, and most recently, long term care insurance programs, the Group Insurance Trust (GIT) continues to serve over 6,500 MSMS members, their families and employees.

During the past year, over $20 million in premiums were billed for health and dental insurance. Approximately 12,000 phone calls were taken in regards to the MSMS sponsored health and dental programs. In addition to these activities, GIT has redesigned the Blue Cross Blue Shield (BCBS) sponsored benefits package and begun marketing and administration of group health programs.

The MSMS Sponsored BCBS Health Insurance Program continues to grow. Over 240 new contracts were added last year. The Group Insurance Trustees authorized modifying certain options of the health program, resulting in significant premium savings for individuals with these options. An optional drug program was also added to the MSMS coverage. This option has proven to be very popular as approximately 10 percent of the subscribers now have this option. Premium increase for the health insurance program averaged seven percent for the group. With the addition of the ability to sell and administer group programs, the Trustees believe the MSMS sponsored Health Insurance Program continues to be a very attractive member benefit.

The MSMS Delta Dental Program continues to gain additional contracts. MSMS was the first association to develop and offer a Delta Dental Benefit Program to its members. Premiums for the last year were not increased and there will be no premium increase for the next year.

The Trustees continue to work with the Stratton-Cheeseman Agency to market other types of programs. During 1990, the MSMS sponsored Disability Program was revised and a major marketing effort was directed at the members. Along with the sponsored disability program, the Trustees, in conjunction with the Stratton-Cheeseman Agency, continue to revamp all the other sponsored insurance programs for MSMS and will be introducing these new programs as they are completed.

In addition to these programs, the Trustees have recently authorized the endorsement of a new long term care insurance program, offered through the AMEX Insurance Company. The Trustees believe long term care insurance will be a product many of the MSMS members will seriously consider, and they feel this is the best overall product offered by a company that has been in the market long enough to establish a record of reasonable premiums.

The Group Insurance Trustees continue to work to make the MSMS member insurance programs a significant benefit of belonging to MSMS. The products offered are of the highest caliber and continue to thrive in the market. The Trustees believe an additional advantage to using the MSMS sponsored program is the commitment to provide administrative support for the subscribers. MSMS is one of the few associations providing direct administrative support for its insurance programs and the members of MSMS continue to respond positively to these member benefits.

The members of the Trust include: Jack L. Barry, MD; Billy Ben Baumann, MD; Henry Domzalski,MD; William E. Madigan; W. Peter McCabe, MD; Earl Moehn, MD; and Robert E. Paxton, MD.

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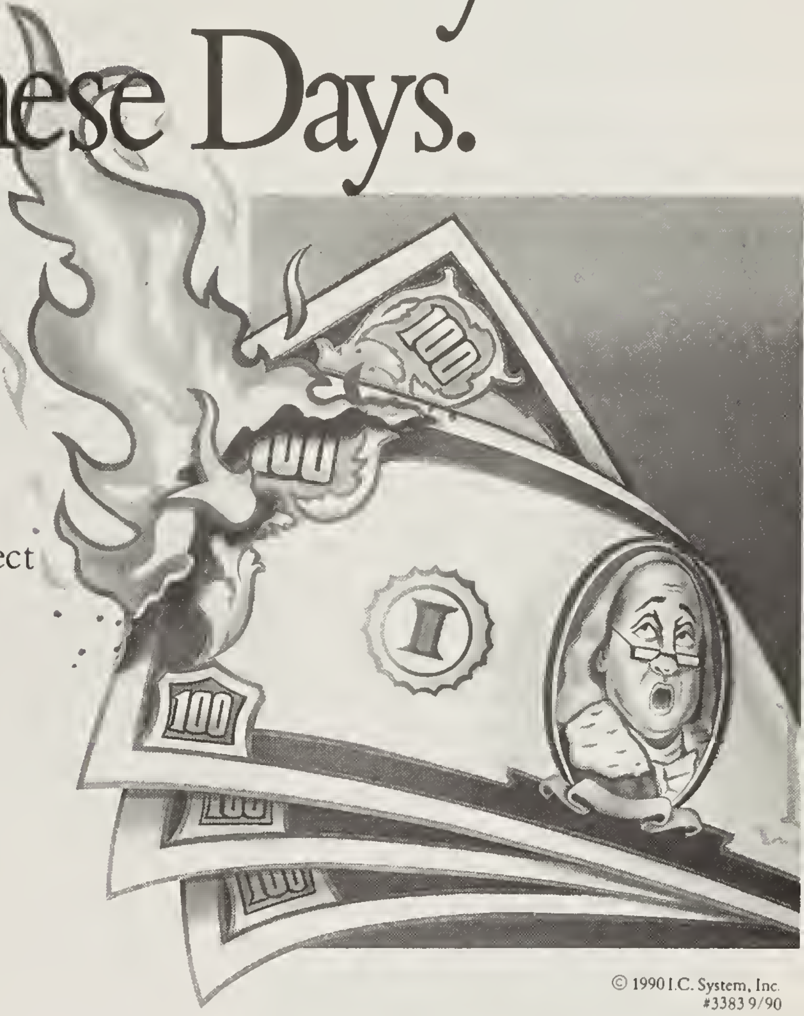

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Our patients need to know we care, says Susan H. Adelman, MD

MSMS President Susan H. Adelman, MD, bid farewell to delegates at the 1991 MSMS House of Delegates meeting.

A plaque on a wall says: "All our guests bring us pleasure, some by coming, others by leaving." I could say the same about the presidency of MSMS. Election to this position gave me great honor and great pleasure. Now I am leaving; this too is sweet.

My election gave me a precious opportunity to make a difference, with my pulpit the Michigan State Medical Society. I felt pressure through this year to do as much as I could while I held this position. At the same time, I enjoyed demonstrating what a woman can do as president of MSMS, in case anybody still needed to be pursuaded. I loved meeting the movers and shakers of this state, as well as those who neither move nor shake very much. I relished the chance to write the President's Page in *Michigan Medicine* for a whole year. One of my greatest pleasures though, over the past two years, was to get to know so many more of you.

I learned that most of you share my concern about what our state is doing to Medicaid, even if you practice in a rural community, in northern Michigan, or in the thumb. It was a delightful surprise to find out that you also share my interest in the environment. When we called for participants in our Task Force on the Environment, we were overwhelmed by your enthusiasm. I am gratified now to see the number of environmental resolutions before this house.

Judging by your response to the MELL program in Wayne County last fall, you also agree with me that it is important to educate Michigan children about substance abuse. We plan to repeat this effort, with a broader reach, next year. A Task Force on Physician Education is now writing a comprehensive handbook of diagnosis and treatment of substance abuse, and of the available resources for the practicing physician.

The last thing you have taught me is that you respond best when I present the full complexity of our many problems, like alternatives to the tort system. You dislike oversimplifications just as much as I do, and you feel more confident that MSMS knows what we are doing when we share our doubts and concerns with you. I like that. It meant that I could be extremely honest when I talked with you about our choices.

Now I am leaving this position, and I can hardly believe it. I wish I could say that I leave a job well done. Actually, it is impossible to finish this job. I have started more projects than I can finish in one year, and I seem to be leaving in the middle of most of them. Still, now I can continue working on some of my unfinished business, and for the rest of the time, I can go back to my practice, presumably before my referring doctors have forgotten me. For all of you who are out there, I am back, as of Monday. You can start sending patients again.

We must show concern for our patients

Since I am leaving now, not starting, I would like to indulge myself and preach a bit. We all know that our medical system is changing. The questions are: how, how much, and how fast. If we expect to play an important part in this change, we will have to clearly show that our concern is not just for ourselves, with rhetoric cloaked in the language of concern for patients.

In the legendary good old days, doctors were revered. Then our compassion and our old uncertain results were replaced by scientific techniques, impersonal technologies, forbidding payment systems, and much better results. Not surprisingly, patients do not like us that much better. Patients want us to care about them, to be competent, to not leave them sitting in our waiting rooms too long, and to send a reasonable bill.

On the other hand, payers want us to run our offices like businesses. Then they tell us that doctors are only interested in making money. We live torn between a vision of our profession as a calling and our practical need to manage the business of our work.

In the past, patients rarely sued us. It was shameful to sue good old Doc Jones, who took care of the family for years. Even if some doctors were wealthy, patients did not resent them, because they knew how hard they worked, and how much they cared. Now, many of us refuse to take care of Medicaid patients, or any patients who cannot pay. We cite our right to make a decent living, complain about our professional liability premiums, then we drive away in our luxury cars. Now we are reaping a rich harvest of public resentment. This is why the public no longer rallies protectively around us, and it does not hesitate to attack us.

Giving charity care fulfills our biblical duty to the poor, and it also protects the profession. The biblical injunction was to give a tenth of one's income to the poor, and the advice is as good today as it was then. Of course, now, with Medicaid paying most of us less than costs, if the patient we are treating charitably sues us, we pay a high price for the privilege of giving to the poor. This unacceptable situation must be solved by the legislature, which needs to show leadership and compassion. We need a solution, and it must include both adequate payment levels to let these patients not be charity cases, and it must include liability relief.

Wayne County is very proud of our project, Health on Wheels, which brings health care to needy Detroiters in a mobile van. This is a noble effort, but it resembles stopgap measures used in Poland after the Second World War. It is fantastic to think that we have come to this in America, in the midst of plenty.

This year, MSMS struggled with a federal mandate for Medicaid to pay pediatric and family nurse practitioners directly. Why did Congress mandate this? We all know it was because so many doctors refuse to treat Medicaid patients.

In fact, through the efforts of MSMS, Medicaid does now require a collaborative agreement between the nurse practitioner and a physician. Nurses do not like the word supervision, but any physician who enters into such a relationship must supervise the nurse for whom he or she takes responsibility, if only to minimize the physician's increased professional liability exposure.

In a special program initiated by Chrysler, BCBSM will soon pay nurse midwives directly. Rep. Perry Bullard has introduced legislation which mandates that BCBSM and all private insurers pay nurse midwives directly. This was predictable, with so many obstetricians dropping deliveries because of the professional liability risk. Whatever the reason, the message we give to the public is the same. Doctors are not willing to sacrifice in order to take care of people in need, but nurses will. Nurses care.

Through the efforts of MSMS, BCBSM changed the plan that they originally submitted for paying nurse midwives. They now require a collaborative, or interdependent relationship between the midwife and the physician. Again, while the words are delicately shaded to protect some sensitivities, the result again is physician supervision, with increased physician liability, we assume.

Even though we have had some successes this year, if the public believes that nurses are more willing to help them, they will allow nurses to broaden their scope of practice, so they can do what we are not willing to do. If we do not watch out, nurses will win the battle for all primary care, and for the hearts of the people.

So far, nurses pay less for professional liability insurance than doctors do. This may be because the public sees them as poorer than doctors, but it may also be because they are seen as more caring. When we build our coalition for professional liability reform, we need to emphasize that we are trying to help patients more than ourselves. If we support a worker's compensation system, this is because injured patients will actually receive a reasonable percentage of their own awards, in a reasonable amount of time.

While we know that a cap will limit the benefit to one severely injured patient, we are more worried about a single $19.7 million dollar award crippling the ability of one hospital to deliver 10,000 babies a year. While our hearts go out to one patient with a truly bad result, we fear that our current liability premiums, with the Medicaid cutbacks, will deprive many patients of needed medical care.

We must search our hearts

Here is where each of us must search our hearts. If we refuse to take care of Medicaid patients, or high risk patients, is this because we are unable to afford a cut in our incomes, or is it because we are unwilling? Let us be honest with ourselves. There is a world of difference between the two. If we are unable, OK, that is how it is. If we are unwilling, this will be recognized by the media, by the Michigan Trial Lawyers' Association, and by the public, as just plain selfishness.

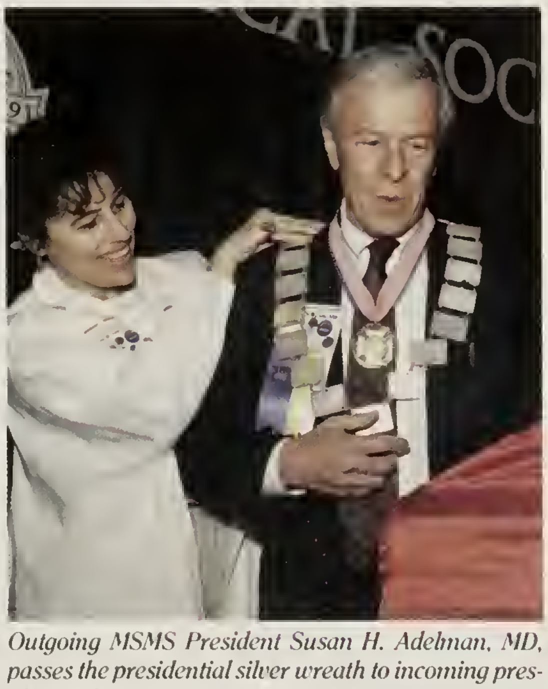
Several states are now considering what lawyers call "poor laws." These ask for at least one of the following: state funds to cover liability for treating injured pediatric patients, extension of the Good Samaritan statute to cover deliveries of mothers with no prenatal care, extension of state employee immunity to include Medicaid obstetric care, limiting liability for delivery of neurologically impaired babies, or indemnification of volunteers who serve in free health clinics. Illinois just passed a bill to provide civil immunity to doctors who provide free care in a community-based free clinic. Apparently it passed easily, too. I strongly believe that we in Michigan need the same degree of protection, for the sake of our patients far more than for ourselves.

Let's face it, there are two reasons why society is pushing for change in the health care system: high health care costs, and the poor. The driving force for the payers is to lower costs. The public feels sympathy for the poor, as long as they do not have to pay much to subsidize their care. Payers use sympathy for the poor to build a constituency for change, under the guise of a need to cover the uninsured.

Right now in Michigan, there are two efforts underway to push the Canadian health care system. Rep. Perry Bullard has introduced legislation to that effect, and a group of labor and big business, called the Health Care Group, has been called together to promote a recommendation for changing our system. I sit on this, and I can tell you that it is going to take a major effort to keep it from espousing the national health care plan of the UAW. The needs of the poor surely can be better served than this, but we, the medical profession, must retain the moral authority to shape the change.

Changing the subject, few of you could know how many hours MSMS has spent in the last two years on the new BCBSM Physician Agreement. We are proud to say that we have brought it from an early, primitive form to the greatly improved, high state of perfection that you all dislike so much. In 1990, we met biweekly for several months in a Physician Advisory Committee, in which MSMS and MAOPS tried to make it clear to BCBSM what contract language would set well with physicians, and what would not.

An appendix of the physician agreement then created a Physician Contract Advisory Committee, which has representatives from MSMS, MAOPS, the UAW, and the major payers. This committee has the authority to change the contract, and it is able to facilitate BCBSM Board acceptance of its changes. On February 27, this committee rewrote the con-



Outgoing MSMS President Susan H. Adelman, MD, passes the presidential silver wreath to incoming president Robert D. Burton, MD.

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tract's objectionable definition of medical necessity. It took six hours of BCBSM staff shuttling between us and the payers, but when we finally reached an agreement, it passed through all the necessary committees and the Board in two weeks. Never in the history of relations between MSMS and BCBSM, have we sat at the same table as payers and the UAW, and never before have we had the opportunity to turn around a contract, the way we are doing now.

This contract advisory committee also will study physician reimbursement, in comparison with surrounding states. What we need to do is expose some of the myths that surround our utilization in Michigan. Then we should be able to make headway for Michigan physicians. The appeals process, the issues of direct supervision of residents or other assistants, experimental or investigational procedures, and expert reviewers from the specialty societies are all being addressed. We know that outside attorneys want BCBSM to rewrite the contract, but we are doing, right now, what they only hope to do eventually, if their appeal of the Physician Provider Class Plan is successful.

Then there are the issues raised by Doctor Kevorkian. Judging by the media interest this past year, this has been a gut issue for the public. Some people are afraid their doctor might decide their lives are expendible, but many others are afraid that without Doctor Kevorkian's machine, nobody will be willing to help them if they want to escape the pain of a terminal illness. Now Sen. Dillingham and Rep. Ciaramitaro feel that we need legislation, to be sure that Michigan does not become the suicide capital of the country. The original draft of their legislation would have imposed criminal penalties on doctors who prescribed sedatives which might shorten the life of a suffering patient. After multiple consultations with MSMS, the recent version is better. Even so, the exclusions that have been put in to protect good medical care still are not written adequately or comprehensively.

The public wants to be sure that we will care enough for them to help them, even if it is to help them die. Their fear is that we will be so worried about our image that we will refuse to help them. At the very least, we need to do a better job of educating the public and the legislature about what we are able to do to relieve suffering. We will help to guide our legislature and our judiciary on these matters, and we as a profession need to bring greater depth to our present position.

Words of thanks

As I complete this year, I have many people to thank. First, I have to thank my husband, who actually loved every minute of it, almost. Next, I owe a special thanks to both my secretary, Elaine Anderson, and Donna Farougi at MSMS, who coordinated my practice, my MSMS responsibilities, my private life, and everything else they could organize, so I could do everything which had to be done. The entire staff of MSMS, Bill Madigan, Kevin Kelly, and everyone did everything they could to make this year enjoyable, or at least possible. Dave Fox did his best to be sure that somebody from the press called whenever I was in the middle of office hours, or right after I finished a day of surgery, and I owe him particular thanks for that.

My colleagues who covered me for the emergencies I could not get to did their part, and so did those of you who sent emergencies to someone else, for the past year, anyhow. Finally, many, many of you were so gracious to me and to my husband. You wrote me and you told me how much you appreciated my efforts, and you extended us so many courtesies, that I do not know how to thank you. Let me just say thank you, and God bless. ■

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We must balance our desires with reality, says Robert D. Burton, MD

President-Elect Robert D. Burton, MD, discusses his goals for the coming year as MSMS president.

Last fall my wife and I took a very interesting trip to a very fascinating country — India. Particularly interesting to me was Bombay because it is the birthplace of one of my favorite authors, Rudyard Kipling.

I've always enjoyed Kipling's works. You know them. Gunga Din. Kim. The Jungle Book. One of my favorite quotes from Kipling will be my guide, and set the tone, for my presidency.

The quote is this:

"If you can keep your head when all about you are losing theirs and blaming it on you, then you are a man, my son."

I'd like to paraphrase this quote to say:

"If you can keep your head when all about you are losing theirs and blaming it on you, then you are a *doctor*, my child."

This is typical of the situation we find ourselves in these days as doctors. Everyone around us seems to be losing their heads. And blaming it on us. But we, above all, cannot afford to lose our cool. We must remain calm, but firm. We must be forthright. We must hold our ground as the tempest swirling around us threatens to erode our very foundation. We must be doctors. We must draw a line in the sand and then stand prepared to do everything in our power — and we really do have quite a lot of power when harnessed properly — to win the battle.

Now that's easy to say. But as we are attacked daily on every conceivable front, it's not that simple. How do we do it? How do we maintain what we have always stood for in the face of such adversity?

Let me tell you my thoughts on approaching these problems during my presidency of the Michigan State Medical Society.

My wife will tell you that I am a perpetual optimist. However, I am not *blindly* optimistic. I don't buy one lottery ticket and expect to win a million dollars.

No, the secret of my optimism is to balance desires with reality. The closer the two are in the beginning, the better the chance for success. When you are way out here in your desire for the ideal, and when the reality is way out here, your chance of successfully achieving your desire is minimal. But when your desire is here, and reality is here, you have a much better chance at affecting that reality and getting what you desire.

Examples of balance

Let me give you some examples. Four issues affecting doctors can show you how this works. They weren't choosen because they were the top four priority issues. They were chosen because they fit neatly into categories in the old wedding rhyme listing the items a new, young bride traditionally wears on her wedding day: "Something old, something new, something borrowed, something blue."

In fact, this wedding rhyme is doubly appropriate. I am optimistic and excited about my term as president as any new young bride is about her future. But I'm not wearing anything new, borrowed or blue. Just this same old suit.

Anyway, the four issues: something old, something new, something borrowed, something blue.

Professional liability

Something old. You have probably already figured out my selection for something old. Professional liability. It's been around for decades and we're still working on it.

What is the ideal in professional liability? The ideal is way over here. The ideal is having the legislature pass a new law banning trial lawyers from suing Michigan doctors. The ideal is having a legislature that agrees there is truly a problem and wants to do something about it. The ideal is having 100 percent patient compliance with our treatment and instructions. The ideal is 18,000 doctors in Michigan treating nine million people without a single mistake, or a single maloccurrence.

But wait. Reality is over here. Reality is that Michigan has a huge number of trial attorneys who are very well organized and are very well ingrained in the fabric of Michigan politics. The reality is that the legislature remains split along party lines on the liability issue; the Republicans control the Senate and the Governor's office, but Democrats still own the House. The reality is that many patients are non-compliant, and that doctors do make mistakes and there are many, many cases of maloccurrence masquerading in the courts as malpractice.

So what do we do? We develop a plan of action based on desires that fit into current reality, and we use every resource available to make these desires the new reality.

By now, surely all of you are familiar with our strategy for professional liability reform. We will be working in a coalition with the Michigan Association of Osteopathic Physicians and Surgeons and with the Michigan Hospital Association to support tort reforms and an alternative dispute resolution system. Both are contained in Senator Joe Schwartz and Dan DeGrow's new bills introduced on April 9. We call these bills "the Michigan

Alternative."

To recap quickly, the Michigan Alternative will offer a patient either the traditional court system or a new, faster system with local panels making the liability determination. The legislation includes a limit of $1.5 million on economic damages and a $225,000 limit on non-economic damages. It eliminates three important exceptions on the current non-economic limit and it reduces the statute of limitations in several areas. The Michigan Alternative also calls for stricter criteria for expert witness qualifications and requires 180-day notice to file a suit. Both senators assure us that, based on the current political realities, with the Governor and the Senate able to squeeze the House on other issues, our desires as contained in the Michigan Alternativesmay become the new reality.

But being realistic, we are not putting all of our eggs in one basket. We have other desires. One is countersuit legislation. Another is a state legal expense fund for physicians offering prenatal, obstetrical or pediatric care to Medicaid-eligible women.

We also plan to expand our coalition to hundreds of businesses, senior groups, consumer groups, professional associations and local governments. We are asking them to join us in petitioning the Michigan Supreme Court to re-institute a sliding scale contingency fee for trial attorneys. Currently, trial lawyers take a third of most settlements or awards. We are asking the Supreme Court to adopt a sliding scale, where the percentage an attorney is allowed to take goes down as the amount recovered goes up.

And finally, we will continue to support an improved physician licensing and discipline system. The improved system will include a nine-month limit on actions and additional funding for more investigative staff.

MSMS has been vitally active in these proposals. We have not stood by, waiting for change to be foisted upon us. We have taken the lead. We have voiced our opinions and concerns. We have shaped this legislation to the greatest extent possible, and that is to a very great extent. But none of this will prevail without our continued efforts and continued support.

Up to this point, we have kept our heads and we have matched our desires as closely as possible with reality. Now we must remain calm, but firm. Be forthright. Draw that line in the sand. And hold our ground. Because our cause is right.

Turf issues

Now, that was something old. What about something new? Probably the newest issue facing medicine is the battle over turf. Who can do what to whom and when and get reimbursed for it?

Unfortunately, the ideal is once again way over here. The ideal is that government, third-party payors and the public recognize that doctors, and only doctors, are the ones qualified to make the critical diagnosis and treatment decisions for patients. The ideal is that these groups should be willing to pay for quality health care. The ideal is that a physician has unlimited time to spend with each patient. The ideal is that there are enough physicians everywhere to provide all necessary services to patients.

The reality is this. Government and third-party payors are looking at the bottom line, not the quality line. To them, whoever provides a similar service for the lowest price is the best.

That might be the case when buying fertilizer fresh from the farm, but we're talking about medicine. The reality is that health care inflation is 9.2 percent compared to overall inflation of 4.9 percent and everyone is looking at cutting costs. The reality is that nurse midwives will deliver a baby for half the price of an obstetrician. The reality is that physicians need allied health care workers to do some of the work.

So what do we do? In this case, there is no question. We are the doctors. We are the only ones educated, licensed and qualified to take care of sick people.

We will fight every attempt by others to expand their scope of practice. We've traditionally fought to protect the public before and we've often won. We will do it again. The chiropractors are coming back with a bill to expand their scope of practice. They want to go beyond manipulation of the spine to other parts of the body. The optometrists want to prescibe and administer therapeutic medications. In both cases, MSMS will fight to protect the public. We will stop these bills as we have in the past.

Recently, nurse practitioners thought they had the right to directly bill Medicaid for 280 different procedures. We differed with them and prevailed. Now a collaborative practice agreement is required between the doctor and nurse practitioner before anything can be directly billed.

We as doctors must maintain our patient advocate role. Our patients depend on us for quality care and we must provide it. Allied health workers will diagnose and treat my patients just as soon as they show me their diploma from medical school.

Ethics

Now let's look at something borrowed. Something borrowed from religious history. Borrowed from law. From Hammurabi and Hippocrates. Something borrowed is ethics. Ethics and the dilemmas we face as technology advances faster than ethics can keep pace.

Ideally, there would be no ethical problems if we were the gods the public sometimes wants us to be. We would make our decisions over life and death and that would be it. Ideally, every baby born would be perfect. Ideally, everyone would die peacefully in their sleep with no lingering, painful, costly disease. No options to explain, no choices to make.

But we know there is a stark reality here. We have the technology to keep patients alive — despite the quality of their lives — as long as they or their family want to keep the machines running. We have the technology to save a one-pound baby — with all of its resulting special needs — that not long ago would not have survived birth. We have a growing older population, a group concerned more about quality of life than length of life; people who want their lives to end rather than continue a painful, debilitating existence.

So what do we do? We, as a society — the public, doctors, lawyers, philosophers, legislators, the clergy — must examine our consciences and come to some consensus, some conclusions. That's a tall order and not easily accomplished. And it won't be accomplished quickly. Right now society is asking us to do it ourselves, to determine the ethics. But we also see lawsuits and arrests.

All of you know that Michigan became the world's center of ethical debate last June when Doctor Kevorkian showed Janet Adkins how to operate his suicide machine. Our Bioethics Committee and Judicial Commission grappled with the issue and brought a new policy statement to the Board.

The AMA's Committee on Ethical and Judicial Affairs was asked by the Michigan Delegation to review the issue. And now our legislature is debating a bill to outlaw assisted suicide. We have been supportive of efforts to develop an ad hoc committee of those I just listed to discuss and debate the issue. It is one that has to be decided by society as a whole, not just the physicians.

Several of the cases that became ethical and legal milestones may have been resolved if the patients had made known their wishes concerning medical care before they became incapacitated. A new Michigan law, long supported by MSMS, may be helpful. The law allows people to appoint a patient advocate to make decisions for them — if they can't — regarding life and death issues, such as removing life support, and artificial nutrition and hydration. MSMS also will continue to support living will legislation.

The Blues

And now, finally, something blue. What else could it be? Blue Cross Blue Shield of Michigan.

Talk about extremes between the ideal and the reality. The ideal is way, way over here. The ideal has BCBSM paying a fair price for services. The ideal is no second guessing on every procedure. The ideal is eliminating the 40 percent disparity between what the Michigan Blues pay compared to what the Blues pay in five surrounding states. The ideal is getting paid before three months or more passes. The ideal is a Blues service rep answering your call on the second ring and saying "Thank you for calling Blue Cross Blue Shield. How may I help you?"

Now, the reality. We all know the reality. We live the reality every day. The reality is that the Blues' major customers, the Big Three Autos and the UAW, are trying to ratchet down their costs by every means possible. The reality is that ever-changing claims requirements and ever-present medical necessity reviews are driving all of us — physicians, office staff and our patients — crazy. The reality is that Michigan physicians are reimbursed, on average, 40 percent less than our colleagues across the state line. The reality is that we frequently are not reimbursed in a timely fashion. And the reality is that you usually have the choice when calling the Blues with a problem; listen to a busy signal for 10 minutes or hang it up.

So what do we do? Those faint of heart may throw up their hands in anguish and say, "There is nothing we can do against an impenetrable monolith like Blue Cross Blue Shield." But fortunately, the physicians of MSMS are made of sterner stuff.

We have developed three chinks in the Blues' armor. They are the MSMS Liaison Committee with Blue Cross Blue Shield, the Special Blue Cross Blue Shield Committee and the Blue Cross Blue Shield Physician Advisory Committee. Members of all three of these MSMS committees, doing yeomans' service, have made great progress for you.

I won't go into each committee's work, but collectively we have been able to do a lot. Probably most important, we recently changed the definition of medical necessity criteria. In the new contract it stated the Blues would determine medical necessity. The new language that we demanded, now states unambiguously that "Medical Necessity is determined by Physicians." In addition, MSMS has reviewed the qualifications of the Blues' reviewers. We have found many specialties missing and too few reviewers in active practice. With the help of specialty societies, we are getting additional Blues reviewers in active practice and we will continue to get more.

The next major push will be to determine why Michigan physicians are paid 40 percent less than those in five adjacent states for the same procedure. The Blues says it's overutilization. We want more of an analysis than that. We want them to look at our liability situation. We want them to look at the fact that Michigan residents have the highest incidence of premature death from nine chronic illnesses. We need to look at this external data to find out what is really acccountable for differences in utilization. Then we need to discuss the potential for change in both utilization and payment. A 40 percent disparity is a lot, and we intend to be pit bulls about it.

There are scores of Blues problems we are working on. We've got them to agree to pay interest on delayed claims; we've got them to put a cap on the cost of appeals; and we're working on exceptions to direct supervision requirements and approval of new procedure codes. (In April) we got them to add more than 20 service reps. And, in case you're not aware of it, we have a Blues ombudsman at MSMS Headquarters now who can cut through the Blues busy signal if you have a particularly sticky problem.

Reachable goals

The list of what we have accomplished and what we are still pursuing goes on and on. The point is this. We are targeting goals that we believe are reachable. We are not trying to reshape the Blues with one stroke. We are identifying digestible pieces and locking our jaws around them. And our method is working.

These four issues — something old, something new, something borrowed, something blue — are just a handful of the dozens and dozens of issues facing doctors and MSMS these days. Sometimes it seems the world has gone mad — with everyone losing their heads and blaming it on us.

But I remain optimistic. And you must remain optimistic. We can keep our heads. We can prevail if we match our desires with our reality. We can and we must prevail to preserve our profession and protect our patients.

I would like to close today with another quote from Rudyard Kipling. It is this:

"Our England is a garden, and such gardens are not made by singing 'Oh, how beautiful!' and sitting in the shade."

The only way the Michigan State Medical Society functions so effectively is to have an active membership willing to pay the dues, both literally and figuratively. MSMS is working for every physician in Michigan, and *every* physician in Michigan should be a part of MSMS.

Take this message back to the doctors you represent. Tell them we are working on difficult issues. Tell them we are making headway. Tell them we need their continued support. Tell them we may not be able to provide everything they desire, but tell them we are taking a long, hard look at reality and trying to affect it to reflect their desires.

And tell them to keep their heads. Remember, after all, that we are doctors. And we should never forget it.

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Nine MSMS past presidents gathered for a photo the evening of the presidential ball. They are (l to r): John J. Coury, MD; Robert E. Paxton, MD; Thomas R. Burglund, MD; Susan H. Adelman, MD; Brock E. Brush, MD; Carl A. Gagliardi, MD; Fred W. Bryant, MD; Donald K. Crandall, MD; and Richard J. McMurray, MD.

It is the responsibility of the 34-member Board of Directors to carry out the dictated policies of the House of Delegates and to act for the Society as a whole and for the House of Delegates between sessions of the House.

At the 1990 House of Delegates meeting, four resolutions were sent to the Board of Directors for further study. Immediately following this narrative are four Actions Reports containing recommendations on those resolutions for House of Delegates consideration and action.

The Board has designated 45 standing committees, liaison committees and task forces to deal with subjects of concern to our members and report regularly to the Board. We have in excess of 600 individuals involved in these committees and task forces who donate countless hours to organized medicine.

On subsequent pages of this report you will find summaries for each of these committees, and you will find that these committees have worked diligently under the direction of the Board of Directors to attain the goals set forth in the MSMS 1990 list of priorities. *(Editor's note: Committee summaries have been omitted from this report.)*

Informational Items

At the risk of duplicating information contained in the committee summaries, following is a listing of the 1990 priorities adopted by the Board and a few of the Society's activities surrounding these priorities:

PATIENT ADVOCACY

MSMS fought for Medicaid patients by initiating the "43 Cents on a Dollar — The False Promise of Medicaid" campaign. After state budget cuts were announced, MSMS attempted to keep the physician portion of the Medicaid budget from being cut further. MSMS is continuing to oppose the budget cuts through letters, direct physician contact with individual legislators, and meetings between MSMS representatives and key members of the appropriations committee. Details concerning these and other initiatives can be found in the Committee on State Legislation & Regulations Summary of Activities, and the Medicaid Liaison Committee Summary of Activities.

Problems in infant mortality were addressed by MSMS including support for a state legal expense fund to cover physicians providing prenatal, obstetrical and pediatric services to Medicaid-eligible women. (See Medicaid Summary of Activities)

In coalition with the Michigan Association of Osteopathic Physicians and Surgeons (MAOP&S), the Michigan Hospital Association (MHA) and the State Bar of Michigan, MSMS developed a Designation of Patient Advocate Form that allows patients to appoint someone else to make care, custody and treatment decisions for them if they become incapacitated. This was in the wake of new legislation allowing the creation of a durable power of attorney for health care. MSMS will undertake a public education campaign to get this information and designation forms to the people of Michigan, and will serve as a vehicle to distribute the forms.

The MSMS Board of Directors supported the AMA 16-point Health Access America plan and is seeking solutions for the uninsured through the MSMS Task Force on Health Care for the Uninsured.

PROFESSIONALISM, COMMUNITY SERVICE AND QUALITY OF CARE

Professionalism, Community Service and Quality of Care

Our continuing medical education program continues to thrive under our Committee on CME Accreditation, and Committee on CME Programming.

CARING CAMPAIGN

MSMS developed and distributed public service announcments on a variety of environmental issues to television stations statewide.

The contributions of MSMS physicians to their local communities were highlighted in "Doctor's Day" materials to statewide media. The publicity campaign included a press conference with Governor John Engler proclaiming March 30 as Doctors' Day in Michigan.

Scores of MSMS physicians underwent media training to help them convey MSMS' message to the public via the media in their areas. They became a part of the Physician Communication Network which is designed to respond to negative press and promote positive press about physicians' activities.

HEALTH CARE COST CONTAINMENT

Oakland County became the first county to set up a community roundtable discussion of health care centered on the cost containment issue. This extremely successful event drew much public and media attention. A panel of six people from various interest groups discussed their points of view, including the AMA's Health Access America 16-point plan. Other counties will be encouraged to establish similar events in their areas.

MSMS' study conducted by Public Sector Consultants entitled "Improving Michigan's Health Care System: Beyond Cost Containment to Serving Patients' Needs" continues to be distributed to government, business, and the press. The report offers innovative perspectives on health care cost containment; emphasizing the need for reliable measures of quality, expanded roles for physicians in containing health care costs and enhanced responsibility for consumers. It has been a valuable resource for several state government agencies responsible for health policy and has encouraged many productive discussions between physicians and local business and community leaders.

CHEMICAL DEPENDENCY

Under the leadership of Susan Hershberg Adelman, MD, MSMS president, a special Focus Group on Chemical Dependency was formed. Last fall the Focus Group participated in the Medicine-Education-Legal-Law Enforcement (MELL) Team Against Drugs Project initiated in cooperation with then Supreme Court Justice Dennis Archer. The giant effort involved putting together 156 health professional, lawyer, and law enforcement teams to present anti-drug programs simultaneously in every elementary school in Detroit. The MSMS program will be expanded to other school districts in the state this year.

The Focus Group has begun development of a physician's handbook for recognizing and treating chemical dependency. Other projects being pursued by the Focus Group include (1) publication of an annotated directory of treatment facilities, (2) inclusion of more courses on chemical dependency in medical school curricula and (3) institution of more hospital program for the joint treatment of the addicted mother and her infant.

MEDICAL LIABILITY REFORM

In a coalition with MAOP&S and MHA, MSMS worked with Senator Dan DeGrow, and Senator John J. H. Schwartz, MD, on the bills they introduced to establish and alternative system for settling professional liability claims and for instituting needed tort reforms. The coalition will work together for passage of these bills during this session of the Legislature. The future of this legislation looks positive because of the election of John Engler as Governor, Robben Fleming's data showing Michigan's high liability insurance premium costs and because of the concern generated by the multimillion dollar jury award against Hutzel Hospital.

The coalition has begun soliciting other groups including business associations, professional associations, other health care groups, and county governments to join in a petition to the Michigan Supreme Court asking for reinstitution of the sliding fee scale for attorneys.

MSMS also is seeking countersuit legislation, supports the bills to improve the licensure and discipline system, and supports the establishment of a state legal expense fund. The Committee on State Legislation & Regulations Annual Summary and the Task Force on Professional Liability Annual Summary will give you further details on all these initiatives.

REPRESENTING PHYSICIANS IN THE LEGISLATURE

MSMS was extremely active in the development of the bills to improve the physician licensure and discipline system and the bills concerning medical liability. MSMS also fought bills that would expand the scope of practice of allied health care workers. MSMS successfully defeated a bill to require physicians to accept assignment on all Medicare claims. The Society continues to provide input into the assisted suicide bill; fight health care budget cuts; and support Senator Schwarz's bill to expand the "Good Samaritan" law.

LICENSURE AND DISCIPLINE

MSMS worked closely with Representative David Gubow, and Representative Rick Bandstra on a bi-partisan package of bills to improve the physician licensure and discipline system. The bills have passed the House and are now in the Senate Health Policy Committee. The bills include a nine- month limit on actions and additional funding for more investigative staff.

THIRD PARTY PAYORS

MSMS physicians and staff spent countless hours in an attempt to favorably influence the new Blue Cross Blue Shield of Michigan physician contract. Without this input, the contract would have been much more unfavorable. A new committee of BCBSM and physicians was established in the wake of the new contract to work on problems that come up as a result of the contract. In this committee, the BCBSM Physician Advisory Committee, MSMS and MAOP&S were able to convince the Blues to rewrite the definition of "medical necessity." The new language states "Physicians determine medical necessity." The findings of a 40 percent payment disparity between Michigan Blues and surrounding states' Blues are under discussion in this committee. MSMS has convinced the Blues to add more than 20 service representa- tives to improve billing problems.

Dozens of issues continue to be discussed with the Blues, with potentially favorable outcomes for many of them. MSMS appointed a staff person as the BCBSM ombudsman who can cut through busy signals and red tape when physicians have particularly difficult problems with the Blues.

In conjunction with the AMA, MSMS vigorously fought "hassle" legislation in the U. S. congress.

As you will see while reading the Liaison Committee with MPRO Summary of Activites, MSMS' role as physician advocate with MPRO is increasing. One major addition was the Board appointment of an MPRO ombudsman position to help you out with any problems with MPRO.

RISK MANAGEMENT

With the support of the Michigan Physicians Mutual Liability Company (MPMLC), MSMS has developed the MSMS Department of Risk Management to increase physician involvement in the planning and implementation of risk management activities. Since its inception, numerous risk management programs have been conducted in locations throughout the state. A priority of the Department is to inventory practice parameter development by specialty societies and coordinate involvement of MSMS members in practice parameter related projects.

MEDIA/PUBLIC RELATIONS

Calls from the media for MSMS positions and statements on a wide variety of health related topics quadrupled last year as MSMS became recognized by the media as a reliable, influential source. Much media attention focused on the right to die issue following Doctor Kevorkian's assisted suicide in Oakland County. Other hot topics included professional liability reforms and state health care budget cuts.

HOSPITAL MEDICAL STAFFS

The Medical Society has taken an active role in aiding hospital medical staff officers and members in matters pertaining to bylaws, credentialing and resolving challenges among the medical staffs, board of directors, and administration. Hospital medical staffs in Michigan were assisted by the Physician Issues Presentation III program. This program makes MSMS officers available as speakers to medical staff meetings on a variety of subjects pertinent to the practice of medicine.

MSMS Task Force on Rural Health was instrumental in the development and passage of legislation to improve the plight of the small community hospital. The Task Force also assisted Michigan State University in the establishment of a Center for Rural Health to address continuing problems.

AIDS

MSMS renegotiated its contract with the Michigan Department of Public Health to continue the very successful AIDS Provider Education Program. This program has provided more than 30,000 people, primarily physicians and allied health workers, with the latest information on the prevention, diagnosis and treatment of AIDS.

MSMS was successful in stopping passage of HB 5701, Mandatory AIDS Education. This legislation would have added education on AIDS and HIV infection to the requirements for licensure or registratrion of health care professionals.

PHYSICIAN RECOVERY NETWORK

The Physician Recovery Network has grown to the point where it is necessary to computerize its records to track those in the program and to analyze data to recognize similar factors leading to chemical dependency and the best reatment regimen outcomes. Funding continued to be a problem last year and will be again this year despite generous grants from MPMLC and the Physicians Insurance Company of Michigan. Grants are being written to seek foundation funding of this important program.

NON-DUES INCOME

The Board approved, primarily for tax benefits, the creation of a new holding company for PSG and PROM, the two wholly-owned for-profit subsidiaries of MSMS. MSMS is the sole stockholder of the new holding company.

The Board also approved the concept of the establishment of a printing company to print MSMS, county society and outside materials. The feasibility of the printing company continues to be explored.

NATIONAL PRACTITIONER DATA BANK

The National Practitioner Data Bank officially went into effect on September 1, 1990. The provisions of the Data Bank require that the following four types of action be reported to the Bank, via the Michigan Department of Licensing and Regulation: medical malpractice payments, licensure actions taken by the Board of Medicine, clinical privilege adverse actions by hospitals or other health entities, and medical society adverse membership actions.

The MSMS Board of Directors remains in close consultation with MSMS legal counsel to ensure that the Society is in compliance with the NPDB reporting requirements, particularly as they pertain to the Judicial Commission, the Physicians Recovery Network and the Hospital Medical Staff Section. In addition, two staff members have been designated to work directly with the Department of Licensing and Discipline and be responsible for receiving and reporting of information in accordance with NPDB regulations.

STRATEGIC PLANNING

The 1990 House of Delegates passed a resolution requesting the Board to appoint a contingency planning committee. At the July 14, 1990, meeting of the Board, Doctor Barry, chairman of the Board, appointed a Strategic Planning Committee consisting of Susan H. Adelman, MD; Robert D. Allaben, MD; Billy Ben Baumann, MD; Robert W. Black, MD; Robert D. Burton, MD; John W. Hall, MD; Gary D. Maynard, MD; W. Peter McCabe, MD; Robert E. Paxton, MD; Marguerite Shearer, MD; B. David Wilson, MD; and Doctor Barry.

The Strategic Planning Committee has met five times. The first two meetings were devoted to obtaining background information to determine MSMS' current position and future possbilities. Subsequent meetings were with AMA planner, Bruce Balfe. A summary of these meetings will be presented to the 1991 MSMS House of Delegates for review and comment.

FINANCES

The 1990 House of Delegates authorized a $90 dues increase. Your Board has made it a top priority to reduce expenditures wherever possible and at its October 31, 1990, meeting approved an extremely frugal 1991 Operating Budget.

The Finance Committee and the Board, as far as possible, met the three-year financial plans approved by the House of Delegates in 1984 and 1987. A comparison of projected versus audited Operating Fund year-end surpluses (deficits) for both the FY 1985-FY 1987 and the FY 1988-FY 1990 plans follows:

The main reason for the larger than projected deficit in FY 1990 was the payment of federal income taxes for both 1989 and 1990 because MSMS can no longer offset the loss from the publication of Michigan Medicine against other non-dues income. In addition, dues income was lower than projected.

For FY 1991, the Board is operating under an austere expense budget of $5,111,300. This is $132,475 lower than the $5,243,775 expense budget contained in the first year of the FY 1991-FY 1993 financial plan approved by the House of Delegates last year.

Financially speaking we had some good news this year. The chiropractic antitrust case was settled without cost to MSMS and we received a favorable ruling from the IRS in the issue of commingling PAC funds with MSMS funds.

POLICY ACTIONS OF THE BOARD

Since the last meeting of the House of Delegates the Board has considered some matters where MSMS policy was not clear or did not exist. In these instances, the Board has taken action which constitute statements of MSMS policy. These statements are given below for the information of the Delegates. They will be incorporated in the MSMS Policy Manual along with the policy actions of the 1991 House of Delegates.

1. Statement on Physician-Assisted Suicide

"The recent use by a Michigan physician of a 'suicide device' to end the life of a patient with Alzheimer's disease attests to concerns deeply felt by many patients — that they will suffer and lose control of their lives as they face chronic and terminal illness. These concerns are reflected in public opinion polls, which consistently show that 50 to 60 percent of Americans favor active euthanasia or mercy killing as an option.

"Hypothetically, the decisions that might be made in terminal illness, or severe chronic illness with severely reduced quality of life, are illustrated by the following spectrum:

1. Discontinuing life support measures;
2. Providing patients with sufficient analgesia to control pain, even though this may depress vital functions;
3. Providing patients with enough analgesic or sedative medication to constitute a lethal dose if taken all at once, with the knowledge that the patient may elect to commit suicide by this means;
4. Directly administering a lethal quantity of *IH11*medication.

"Many physicians would allow #1 and #2 while steadfastly opposing #3 and #4, arguing that the physician must be dedicated to healing and never to causing the death of the patient. Others would argue that the complexities of actual clinical cases make it extremely difficult to draw such a sharp dividing line which can be defended with cogent ethical reasoning. For many physicians who accept #1 and #2 while opposing #4, assisted suicide (#3) represents a moral gray zone.

"The 'suicide device' used in Michigan appears to some in its clinical and ethical implications to be more akin to active euthanasia (#4) than to assisted suicide (#3). While use of the machine may arguably reduce the physician's legal responsibility for the patient's death, the ethical responsibility appears to be as great as if the physician had chosen directly to administer the lethal injection.

"It is not enough, however, to righteously condemn the use of this 'suicide device,' unless we forthrightly address the underlying concern of humane and compassionate terminal care for all patients. While these issues are societal, rather than purely medical, physicians nevertheless have a special obligation to make clear our basic professional values.

"We encourage all Michigan physicians to enhance the quality of care of these patients in the following ways:

1. Become acquainted with the most modern methods of symptom control and emotional support for palliative terminal care, or learn which local individuals and groups can provide such services for their patients.
2. Assure chronically or terminally ill patients that their consent is required before any medical interventions will be used, and invite them to discuss their wishes and values regarding such care.
3. Become familiar with existing modes of advance directives (durable powers of attorney for health care, 'living wills'), ask all patients whether they have executed or wish to execute such documents, and assist them as appropriate in doing so. The MSMS Committee on Bioethics is currently working to compile examples of advance directive documents which appear suitable for use in Michigan."

2. Revision of MSMS Policy on Endorsement of Practice Recommendations.

"a. The development of guidelines, recommendations or protocols which prescribe standards of medical practice is the responsibility of physicians.

"b. MSMS should assume a proactive role in the dissemination of practice recommendations developed by the American Medical Association, its component societies and recognized specialty societies; in the identification of areas where practice recommendations are needed; and in the development of practice recommendations in those areas.

"c. MSMS does not endorse guidelines, recommendations or protocols which prescribe, or may be interpreted as prescribing, standards of medical practice, unless they are endorsed by the American Medical Association, its component societies, or recognized specialty societies.

"d. If a governmental agency perceives a need to develop practice recommendations in response to a pressing public health problem, MSMS will evaluate the need for recommendations and cooperate in the effort through the following measures:

1) If no recommendations are available from the American Medical Association, its component societies and recognized specialty societies, MSMS may offer to convene an expert committee.

2) MSMS, when appropriate, may assist in efforts to disseminate the recommendations to physicians and to the public.

"e. MSMS will continue to promote physician involve- ment in state government committees where physician expertise is needed to assist a state government agency in carrying out statutory responsibilities with respect to the protection of the public health."

Action Items

Action Report #1: 1990 Board Action Report #16 – Stop Michigan Blue Cross and Blue Shield from Joining the Plaintiff in Medical Liability Cases

RECOMMENDATION: That the House of Delegates adopt this report as an interim report in lieu of Board Action Report #16 (Resolution 154-89A) while the Liaison Committee with BCBSM pursues assurance from BCBSM that they will pursue alternative methods of subrogation.

In 1989, the House of Delegates considered Resolution 154-89A, asking that MSMS determine how often Blue Cross and Blue Shield joins medical liability action as a plaintiff, and that we take action to stop the Blues from becoming involved in medical liability cases. The resolution was referred to the Board of Directors for study. A report from the Board of Directors to the 1990 House of Delegates indicated that the Liaison Committee with Blue Cross and Blue Shield had reviewed this issue and determined that this activity was legal. The Board recommended no further action on the resolution, but the House rejected the recommendation of the Board of Directors.

The Liaison Committee with Blue Cross and Blue Shield continues to hear of cases where BCBSM joins as a plaintiff in medical liability cases. While we do not dispute the Blues' rights to subrogation, we are concerned that this activity by Blue Cross and Blue Shield creates an adversarial situation that can be avoided. The Liaison Committee raised the issue in a November meeting, and subsequently corresponded with BCBSM officials asking that they develop alternative methods of subrogation.

Currently, the Liaison Committee is waiting for a response to our request from Blue Cross and Blue Shield. The Committee will work with MSMS legal counsel to review BCBSM's response and to work out a mutually agreeable method of subrogation.

Reference Committee D on Professional Liability recommended that no action be taken on Board Action #1.

The House approved the recommendation of the Reference Committee.

Action Report #2: Board Report #18 – Resolution #111-89A – Schedule II Prescription Drugs

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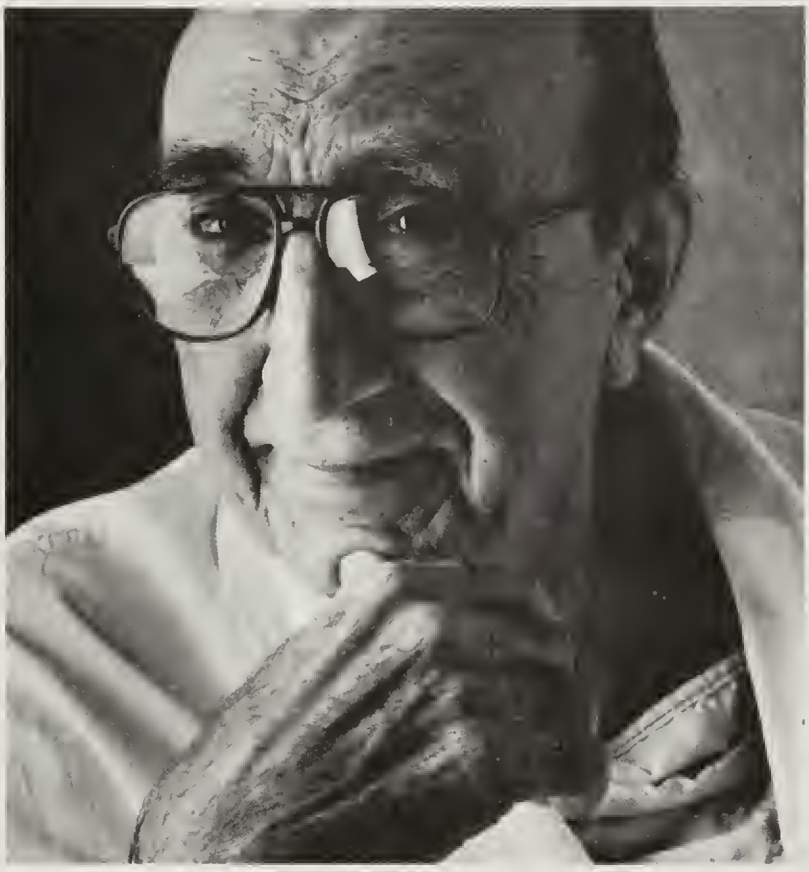

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RECOMMENDATION: That the House of Delegates adopt this report in lieu of Board Action Report #18 – Resolution 111-89A.

Resolution 111-89A (referred to the Board of Directors for study) requested that the MSMS Board of Directors evaluate the drugs currently included in the triplicate prescription requirement and take appropriate action in the study of other drugs that should be included.

The 1990 House of Delegates Board Action Report #18 stated that it is premature to extend the triplicate prescription requirement to additional drugs at this time. That report was referred back to the MSMS Board of Directors for additional study.

The Committee on Medical Licensure and Discipline carefully examined the issue of whether additional drugs should be added to the triplicate prescription program. While the Committee is not aware of any significant problems in the implementation of the triplicate prescription requirement, the Committee continues to believe that, at this time, it is premature to extend the triplicate prescription requirement to additional drugs.

The Committee was advised that because of budget cuts, the Department of Licensing and Regulation may have to curtail the triplicate prescription program. The Committee believes that less onerous means of tracking drugs should be developed to ensure that they are not being overprescribed. The Committee is interested in meeting with officials of the Department of Licensing and Regulation to discuss alternative methods to control overprescribing of benzodiasopines and other drugs. The Committee will continue to closely monitor this issue, and if appropriate, will recommend that additional drugs be subject to the triplicate prescription requirement.

The Board supports the recommendation of the Committee.

Reference Committee B on Legislation recommended Report #2 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #3: Resolution 18-90A – Physician Testimony is the Practice of Medicine

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 18-90A.

House of Delegate Resolution 18-90A (referred to the Board of Directors for further study) requested MSMS to seek legislation that physician witnesses in medical liability cases who are under oath are, in fact, practicing their profession and that this legislation allow the Michigan Board of Medicine to discipline physicians who give false testimony in such cases.

The Board referred the issue to the Committee on State Legislation and Regulations and they recommended that MSMS seek legislation that would amend the current definition of the Practice of Medicine to allow the Board of Medicine to discipline physicians who provide false testimony in medical liability cases and that the House of Delegates adopt this report in lieu of Resolution 18-90A.

At its February meeting, the Committee on State Legislation and Regulations heard from MSMS Legal Counsel regarding this Resolution. The Committee was advised that an alternative approach to this Resolution may be taken that would amend the current definition of the Practice of Medicine and simply add an additional ground for discipline under Section 16221 Sub Paragraph 1 of the Public Health Code.

Therefore, the Committee supports introducing legislation that would provide additional jurisdiction by the Michigan Board of Medicine over physicians who falsely present medical testimony in medical liability cases. MSMS is currently seeking a sponsor for this legislation.

Reference Committee D on Professional Liability recommended Board Action Report #3 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #4: Resolution 78-90A – Unclaimed Bodies as Potential Tissue and Organ Donors

RECOMMENDATION: That the House of Delegates take no further action on Resolution 78-90A.

Resolution 78-90A (referred to the Board of Directors for study and subsequently referred to the Committee on State Legislation and Regulations) requested "MSMS seek to have legislation introduced which would give initial authority over unclaimed bodies to the local Medical Examiner in order to give timely permission for tissue and organ donation."

The Committee on State Legislation and Regulations reviewed this Resolution and was informed that local Medical Examiners already have the authority to release bodies at their discretion. The Committee also noted that most unclaimed bodies have been dead for a time period beyond consideration for suitable tissue and organ donation. The Committee recommended that no action be taken by MSMS at this time.

Reference Committee B on Legislation recommended Board Action Report #4 be adopted.

The House approved the recommendation of the Reference Committee.

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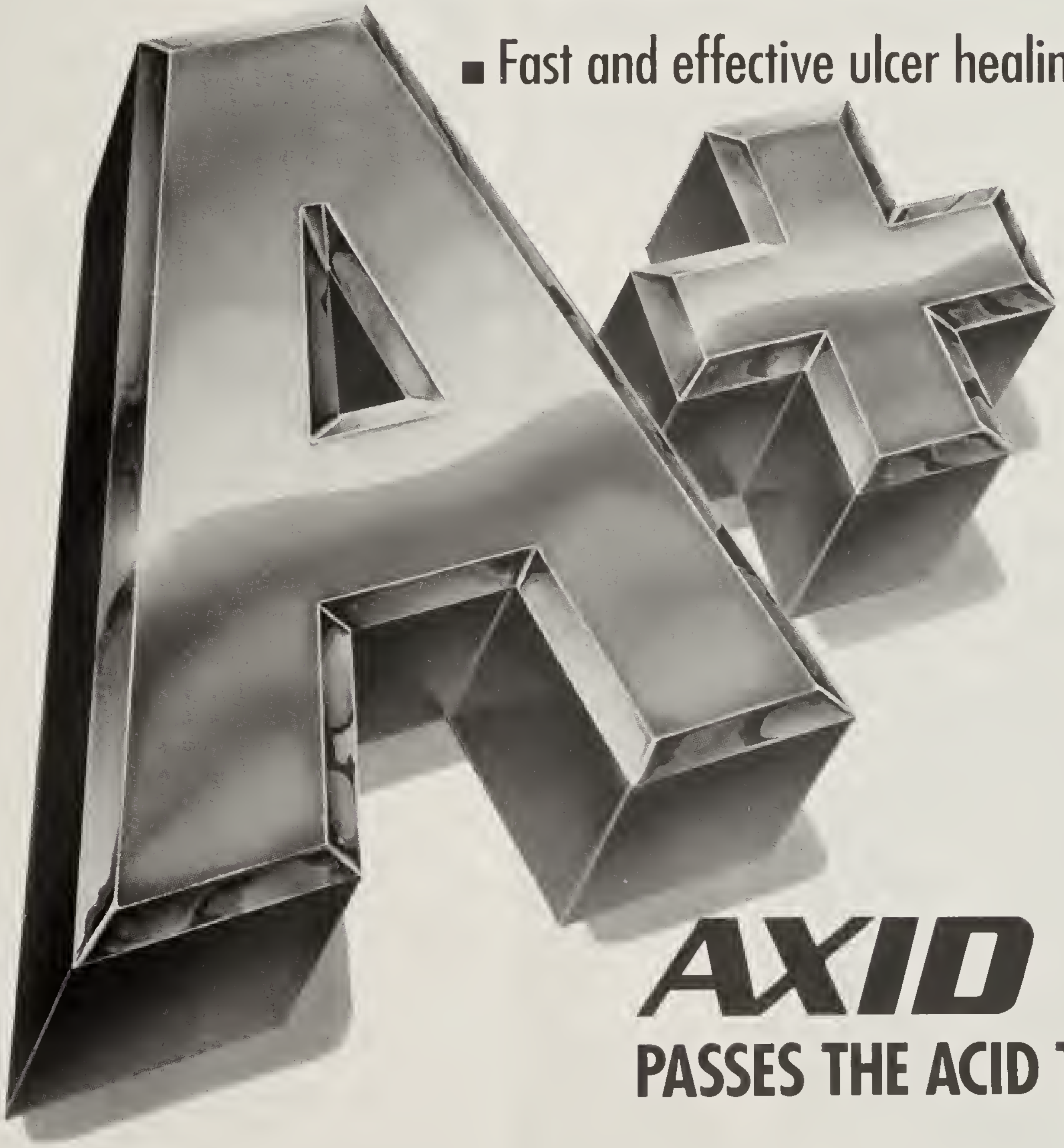

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Indications and Usage: 1. *Active duodenal ulcer* – for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70
3. *Scand J Gastroenterol.* 1987,22(suppl 136):47-55
4. *Am J Gastroenterol* 1989,84 769-774

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Committee on Constitution and Bylaws

Steven E. Newman, MD, Chairman

(This standing committee also serves as the Reference Committee on Constitution and Bylaws.)

The House of Delegates adopted the following Constitution and Bylaws amendments at its 1990 Annual Meeting, on first reading. They were laid over to the 1991 House of Delegates meeting as prescribed in the MSMS Bylaws:

1. "Section Name Change from Graduates of Foreign Medical Schools to International Medical Graduates."

   Amend Section 20.70 by changing the words "graduates of foreign medical schools" wherever they occur, to "international medical graduates."

COMMENT: The AMA Board of Trustees agreed last year to change the name of its Advisory Committee for Foreign Medical Graduates to Advisory Committee for International Medical Graduates. This change took immediate effect. Our own section has been using its new name to conform to current AMA practice. The proposed change will amend the MSMS Bylaws to conform to actual current usage.

RECOMMENDATION: That this amendment be adopted on final reading and incorporated in the MSMS Bylaws.

2. Addition of the Michigan Vascular Society to the official list of specialty societies to be represented in the MSMS House of Delegates.

   Amend the MSMS Bylaws, Section 20.10, to add the Michigan Vascular Society to the list of recognized specialties.

COMMENT: This amendment was adopted by the House of Delegates in 1990 on first reading.

RECOMMENDATION: That this amendment be adopted on final reading and incorporated in the MSMS Bylaws.

In addition, the Committee on Constitution and Bylaws will be considering modification of the MSMS Bylaws to assist in establishing guidelines for consistency in format for Special Sections Bylaws.

Six reference committees heard testimony on a total of 118 resolutions. Testimony is often brings delegates to their feet, as shown above.

Members of the Committee include: R. Paul Clodfelder, MD; Angel Farina, MD; Jack D. Gift, MD; Thomas F. Higby, MD; Samuel D. Indenbaum, MD; Geoffrey A. Wardwell, MD; William E. Madigan (ex officio); Richard E. Weber (ex officio).

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• 1-91A

Bicycle Helmets.

Reed K. Freidinger, MD, Northern Michigan

Referred to the Board for Study.

RESOLVED: That MSMS and county medical societies urge the State Legislature and County Boards of Commissioners to enact bicycle helmet legislation or ordinances requiring cyclists to wear approved helmets at all times.

• 2-91A

Audio/Visual Telecommunication System.

Dennis M. Joy, MD, Northern Michigan

Adopted as Amended.

RESOLVED: That MSMS explore modalities to increase two-way communication with Upper Peninsula physicians so they may become more involved in MSMS activities.

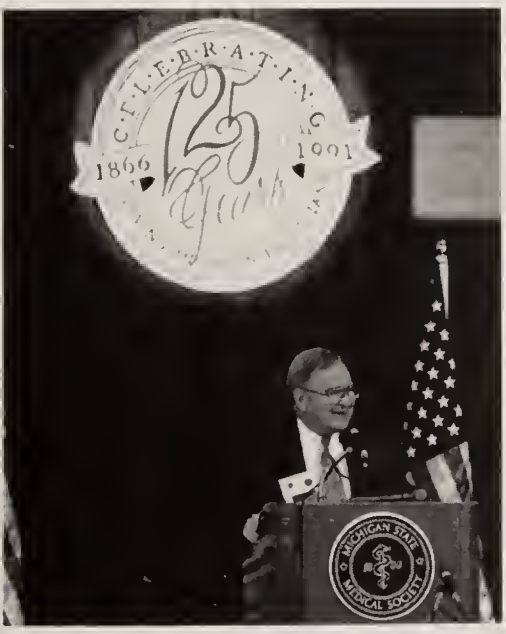
• 3-91A

Benzodiazepine Education.

William D. Doebler, MD, Ottawa County

Adopted as Amended.

RESOLVED: That MSMS undertake educational measurers for physicians about the true addictive nature of benzodiazepines; and be it further
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to undertake a similar program; and be it further
RESOLVED: That one of the plenary sessions at a future MSMS scientific session be devoted to the addictive potential, side effects and morbidity of benzodiazepine use.



Speaker of the House Robert D. Allaben, MD, addresses delegates at the 126th meeting of the MSMS House of Delegates.

• 4-91A

Benzodiazepines to Schedule II.

William D. Doebler, MD, Ottawa County

Disapproved.

• 5-91A

Impact of State Budget Reductions.

James G. Kornmesser, MD, for the Michigan Section of American College of Obstetrics and Gynecology (AGOC)

Disapproved.

• 6-91A

Child Care Availability in Hospitals.

Douglas L. Colberg, MD, for the Young Physicians Section

Adopted.

RESOLVED: That MSMS encourage hospitals in Michigan that do not have child care centers in operation in or near their facility to develop such centers; and be it further
RESOLVED: That MSMS encourage hospital child care centers to be affordable, to be appropriately staffed, to offer flexible hours, and to allow medical students, resident physicians, and practicing physicians to take advantage of these programs.

• 7-91A

Equal Pay for All Physicians.

Douglas L. Colberg, MD, for the Young Physicians Section

No Action.

• 8-91A

Michigan Physicians in the Military Reserves.

Douglas L. Colberg, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS support Michigan physician reservists, and other physicians with unplanned absences, by developing strategies/guidelines that are directed to promote the viability of the practice of these physicians temporarily absent; and that the county medical societies work with MSMS to be the vehicle for the implementation of these strategies/guidelines.

• 9-91A

Bottle and Can Recycling.

Douglas L. Colberg, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS ask the AMA to encourage Congress to tie all federal funding for state highway projects to bottle/can deposit laws.

• 10-91A

Curbside Recycling.

Douglas L. Colberg, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS encourage the State Legislature to provide all public/private garbage collection businesses with basic information on solid waste recycling to be passed on to their subscribers at least yearly; and be it further
RESOLVED: That MSMS encourage the State Legislature to require all public/private garbage collection businesses to offer curbside (residential) recycling pickup services to the subscribers at reasonable intervals of time as part of their basic services; and be it further
RESOLVED: That MSMS ask the AMA to expand existing policy to encourage Congress to require state governments to enact recycling policies in an effort to promote effective recycling of solid waste.

• 11-91A

Health Insurance for Adopted Children.

Douglas L. Colberg, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS support Michigan House Bills 4119, 4120 and 4121, that would extend health insurance benefits to adopted children as they are extended to biological children, with these benefits beginning at the date of placement and covering any and all preexisting conditions; and be it further
RESOLVED: That MSMS ask the AMA to encourage Congress to formulate legislation that would extend health insurance benefits to adopted children as they are extended to biological children, with these benefits beginning at the date of placement and covering any and all preexisting conditions.

• 12-91A

HIV Testing After Accidental Exposure of Health Care Workers.

Douglas L. Colberg, MD, for the Young Physicians Section

Substitute Resolution (in lieu of 12-91A and 105-91A). Adopted.

RESOLVED: That MSMS support legislation that would broaden the exemption

Mark Sawka, MD, chairman of the MSMS Resident Physician Section (at podium), delivers the report of the MSMS Resident Physician Section. Shown in the background are (l to r): Robert D. Allaben, MD, speaker, and Gary D. Maynard, MD, vice-speaker.

from the informed consent requirement for HIV testing under Public Act 488 to include all exposed health care workers in all outpatient settings.

• 13-91A

Young Physicians Section (YPS) Delegate Funding.

Douglas L. Colberg, MD, for the Young Physicians Section

Referred to the Board for Study.

RESOLVED: That MSMS fund all designated delegates of the YPS to the MSMS House of Delegates Annual Session and the Interim AMA-YPS and Annual AMA-YPS meetings for four days each.

• 14-91A

Elimination of Health Insurance for Pre-Existing Conditions.

James H. Saker, MD, Michigan Allergy Society

Adopted as Amended.

RESOLVED: That MSMS investigate the problem of some health insurers eliminating coverage for pre-existing conditions, which is having a significant impact upon the health care of citizens of this state, and make recommendations to appropriate state government agencies.

• 15-91A

Level I Trauma Center Support.

Robert S. Levine, MD, for the Oakland County Medical Society

Disapproved.

• 16-91A

Toxic Waste Disposal.

Edward E. Elder, Jr., MD, for the Oakland County Medical Society

Adopted as Amended.

RESOLVED: That MSMS encourage by appropriate means available the establishment of a program in each county or community in the state for the collection and proper disposal of the toxic residuals found in most homes, such as pesticides, paint, paint thinner, fertilizers, aerosols and poisons.

• 17-91A

Radon Information.

Edward E. Elder, Jr., MD, for the Oakland County Medical Society

Adopted as Amended.

RESOLVED: That MSMS help to establish and publicize hotline phone numbers in the State where residents can obtain reliable information regarding indoor air pollution and testing for, and control of, radon accumulation in all buildings.

• 18-91A

Elimination of Heavy Metals and Benzene.

Edward E. Elder, Jr., MD, for the Oakland County Medical Society

Referred to the Board for Further Study.

RESOLVED: That MSMS work for the elimination of all heavy metals, especially mercury and lead, from paint manufacture; and be it further

RESOLVED: That MSMS work for the elimination of benzene as an ingredient in any product.

• 19-91A

Chemical Spills.

Edward E. Elder, Jr., MD, for the Oakland County Medical Society

Adopted as Amended.

RESOLVED: That MSMS work to ensure that each Michigan hospital with emergency facilities has in place specific plans to handle the victims of the accidental release of chemicals, and that said hospitals be familiar with manufacturing plans in their vicinity that could accidentally discharge specific chemicals (since this information is available from the Environmental Protection Agency.)

• 20-91A

Per Claim Participation with Blue Cross Blue Shield of Michigan (BCBSM).

Alan M. Mindlin, MD, for the Oakland County Medical Society

Substitute Resolution (in lieu of 20-91A and 98-91A). Adopted.

RESOLVED: That MSMS, in recognition of patient needs, investigate ways to challenge the interpretation of PA 350 of 1980 requiring physicians' to accept assignments on all similar procedures for the remainder of the year.

• 21-91A

Anonymity of Review.

Alan M. Mindlin, MD, for the Oakland County Medical Society

Substitute Resolution (in lieu of 21-91A and 28-91A). Adopted.

RESOLVED: That MSMS, in concert with AMA, encourage review organizations to identify the specific physician reviewers responsible for case review.

• 22-91A

Proper Definition of Physician or Surgeon.

Quentin P. Hamilton, MD, for the Oakland County Medical Society

Disapproved.

• 23-91A

Retired Physicians.

Quentin P. Hamilton, MD, for the Oakland County Medical Society

No Action.

• 24-91A

Physician Call to Military Leave.

Jaime V. Aragones, MD, for the Oakland County Medical Society

Disapproved.

• 25-91A

Evaluation of Political Candidates.

Edward E. Barton, MD, for the Oakland County Medical Society.

Adopted as Amended.

RESOLVED: That existing MSMS publications be used to publish statewide political candidates' written responses to specific questions regarding issues that may have impact on the public health and the practice of medicine in Michigan; and be it further

RESOLVED: That county medical societies solicit similar information on local candidates for dissemination through their publications.

• 26-91A

Laser Surgery.

Busharat Ahmad, MD, Marquette-Alger Counties

Adopted as Amended.

RESOLVED: That MSMS work through the State to require that invasive and non-invasive laser surgery be performed by a licensed doctor of medicine or osteopathy who is trained in laser surgery procedure.

• 27-91A

Consolidated Omnibus Budget Reconciliation Act Program (COBRA).

Edward E. Steinhardt, MD, Huron County

Disapproved.

• 28-91A

Michigan Peer Review Organization (MPRO) Review.

Edward E. Steinhardt, MD, Huron County

Substitute Resolution (in lieu of 21-91A and 28-91A). Adopted.
See Resolution 21-91A.

• 29-91A

Post-Operative Care.

Busharat Ahmad, MD, Marquette-Alger County

Referred to the Board for Study.

RESOLVED: That MSMS support the position that post-operative care must be provided by the operating surgeon or an equivalently trained and licensed physician.

• 30-91A

New Policies of the Michigan Board of Medicine.

Robert D. Allaben, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS strongly protest the unheralded decision by the Michigan Department of Licensing and Regulation to no longer provide verbal or written confirmation of current physician licensure to hospital medical staff offices.

• 31-91A

Broaden Continuing Medical Education Credits (CME's).

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

No Action.

• 32-91A

Support for the Appeal of the Determination Report on the Blue Cross Blue Shield of Michigan Medical Doctor Provider Class Plan.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Referred to the Board for Study.

RESOLVED: That MSMS contribute financial and other support to the appeal of the Determination Report on the BCBSM Medical Doctor Provider Class Plan for the calendar years 1987 and 1988 issued by the Commissioner of Insurance on August 16, 1990, which is currently pending before an independent hearing officer in the Insurance Bureau of Lansing.

• 33-91A

Nursing Scope of Practice.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A).
Adopted.

RESOLVED: That MSMS oppose the delivery of medical services by independent nurse practitioners; and be it further

RESOLVED: That MSMS encourage the Michigan Department of Public Health to review nursing policy manuals of each hospital to assure that statements related to the nursing scope of practice, professional philosophy, and mission defined therein, are consistent with the laws of the State of Michigan; and be it further

RESOLVED: That MSMS endorse and support all efforts to require physician supervision of nurse practitioners as required by the Michigan law; and be it further

RESOLVED: That MSMS support the establishment of written protocols between the physician and nurse practitioner.

Charles Vincent, MD, member of the MSMS Board of Directors and an AMA alternate delegate, speaks out on a resolution.

• 34-91A

Identify Illustrations of Defensive Medicine.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Referred to the Board for Study.

RESOLVED: That MSMS undertake a study of "defensive medicine" and its cost impact on total health care costs and also its effect on physician behavior.

• 35-91A

Mandatory Malpractice Insurance.

Magdy M. Hanna, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS reiterate its strong opposition to mandatory malpractice insurance, even if such insurance is tied to a cap on damages or to any other tort reforms.

• 36-91A

Support for the Michigan Model Health Care Curriculum.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS provide support for the Michigan Model for Comprehensive School Health Education by offering help to the instructors and students in the form of lectures and other assistance including program evaluation.

• 37-91A

Medical Insurance Overhead Costs.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS ask the AMA to vigorously pursue a simplified medical billing system for all third party payers.

MICHIGAN STATE MEDICAL SOCIETY
VICE SPEAKER
SPEAKER

Krishna K. Sawhney, MD, chairman of the MSMS Hospital Medical Staff Section, delivers the report of the Section to members of the House. Shown in the background are (l to r): Robert D. Allaben, MD, speaker, and Gary D. Maynard, MD, vice-speaker.

• 38-91A

Public Information Campaign to Michigan Consumers.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Referred to the Board for Study.

RESOLVED: That MSMS expand its current "43 Cents on the Dollar" campaign that addresses the impact of underfunding of the Medicaid program; and be it further

RESOLVED: That MSMS physicians educate their patients about the additional negative effects of present and future budget cuts and encourage them to write letters to their legislators.

• 39-91A

Shortage of Public Health and Preventive Medicine Physicians in Michigan.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS strongly urge the Michigan Department of Public Health, the University of Michigan and appropriate others to take the necessary actions to reinstitute the model Public Health and Preventive Medicine Residency Training Program at the University of Michigan School of Public Health.

• 40-91A

Disabled Physicians Survey.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS continue to conduct, in the most cost effective way, a survey of its membership to ascertain the incidence and nature of the physical disabilities of its members, and the special needs arising there from; and be it further

RESOLVED: That the results of this survey be presented to an appropriate MSMS committee for review and recommendations for possible implementation of new programs as needed.

• 41-91A

Equal Access for Physically Challenged Physicians.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS encourage hospitals to adopt guidelines for equal access to all hospital facilities for physically challenged physicians; and be it further

RESOLVED: That MSMS encourage hospitals and hospital medical staffs to work with physically challenged physicians on their staffs to maximize the utilization of hospital facilities by these physicians; and be it further

RESOLVED: That MSMS encourage hospitals and hospital medical staffs to work with physically challenged physicians on their staffs to maximize the utilization of hospital facilities by these physicians; and be it further

RESOLVED: That MSMS recommend to the AMA that guidelines for equal access to all hospital facilities to physically challenged physicians be adopted as part of the standards of the Joint Commission on Accreditation of Health Organizations.

• 42-91A

Who Sues.

Marion G. McCall, MD, for the Wayne County Medical Society Delegation

No Action.

• 43-91A

County Medical Care Facilities (CMCF's) Mission and Funding

Robert W. Oakes, MD, Calhoun County

Substitute Resolution (in lieu of 43-91A and 44-91A). Adopted.

RESOLVED: That the MSMS Committee on Aging and the County Medical Societies actively participate in expanding the mission of County Care Medical Facilities to long term care of the elderly; and be it further

RESOLVED: That MSMS oppose reductions in state funding for County Medical Care Facilities.

• 44-91A

County Medical Care Facilities (CMCF's) A State Asset.

Robert W. Oakes, MD, Calhoun County

Substitute Resolution (in lieu of 43-91A and 44-91A). Adopted. See Resolution 43-91A.

• 45-91A

Funding for Regional Poison Control Centers.

Sarla Puri, MD, Kent County

Adopted.

RESOLVED: That MSMS focus efforts to maintain funding for the Regional Poison Control Centers with all appropriate agencies of the state government.

• 46-91A

Fair and Equitable Reimbursement for Medicaid.

Doyle E. Calley, MD, Ionia-Montcalm County

Disapproved.

• 47-91A

Physician "Supersignature."

Moufid Mitri, MD, for the Oakland County Medical Society

Disapproved.

• 48-91A

Signing Physician's Orders.

Moufid Mitri, MD, for the Oakland County Medical Society

Disapproved.

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- **49-91A**

Requirements for CME Accreditation.

David Krhovsky, MD, for the Michigan Society of Anesthesiologists

Substitute Resolution 49-91A. Adopted.

RESOLVED: That MSMS, through appropriate channels, re- examine the requirements for Category I accreditation for statewide specialty societies, taking into consideration that "mission statements" " needs assessments" and "educational objectives" are already implicit in the society's bylaws or charter; and be it further

RESOLVED: That MSMS through these same channels strive to eliminate in as much as it is possible, the amount of unnecessary paperwork associated with the accreditation process.

- **50-91A**

Health Care Administration Cost Cap.

John A. Rupke, MD, for the Hospital Medical Staff Section

Referred to the Board for Study.

RESOLVED: That MSMS seek state legislation capping administrative health care expenses at 10 percent; and be it further

RESOLVED: That MSMS ask the AMA to seek similar legislation at the federal level.

- **51-91A**

Physician Payment for Administrative Requirements Pertaining to Non-Ambulatory Home Health Care Patients.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS seek compensation for appropriate physician services, clinical and/or administrative rendered to home health care patients.

- **52-91A**

Environmental Concerns on Non-Reusable Materials.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS encourage medical staffs of healthcare facilities to meet with their administrations, purchasing, central supply, laundry, and nursing services to consider the advantages and disadvantages (not only for the facility but also for the environment of future generations) of the use of re-sterilizable and reusable items in their facilities; and be it further

RESOLVED: That MSMS communicate with the Michigan Hospital Association to stimulate joint discussions to consider the environmental concerns in the purchase, usage, and disposal of non-recyclable materials in hospitals.

- **53-91A**

Alternative Usage of Acute Care Beds.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted.

RESOLVED: That MSMS seek legislative efforts to allow hospitals flexibility to use their acute care beds for alternative care without the threat of losing those beds for acute care status.

- **54-91A**

Michigan Peer Review Organization (MPRO) Accept Collect Calls from Physician Offices for MPRO Medicare Pre-Admission/Pre-Procedure Authorization Review (PAR) Program.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS seek to bring about access to physician reviewers at no cost to the attending physician.

- **55-91A**

Nursing Scope of Practice.

John A. Rupke, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A). Adopted. See Resolution 33-91A.

- **56-91A**

MSMS/HMSS Oppose the Independent Practices of Nurses.

John A. Rupke, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A). Adopted. See Substitute Resolution 33-91A.

- **57-91A**

Change Confidentiality Rules for HIV Positive Patients.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS seek legislation which would place HIV testing in the same category as all other laboratory testing by eliminating the informed consent requirements for such testing.

- **58-91A**

Reconsider Joining AMA National Credentials Verification Service.

John A. Rupke, MD, for the Hospital Medical Staff Section

Referred to the Board for Study.

RESOLVED: That MSMS join the National Credentials Verification Service as a test state at the earliest possible time.

- **59-91A**

Control MSMS Dues.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

Allan C. Brown, MD, delegate, MSMS Section for International Medical Graduates, urges members of Reference Committee F to recommend adoption of a resolution aimed at halting the discrimination of IMGs.

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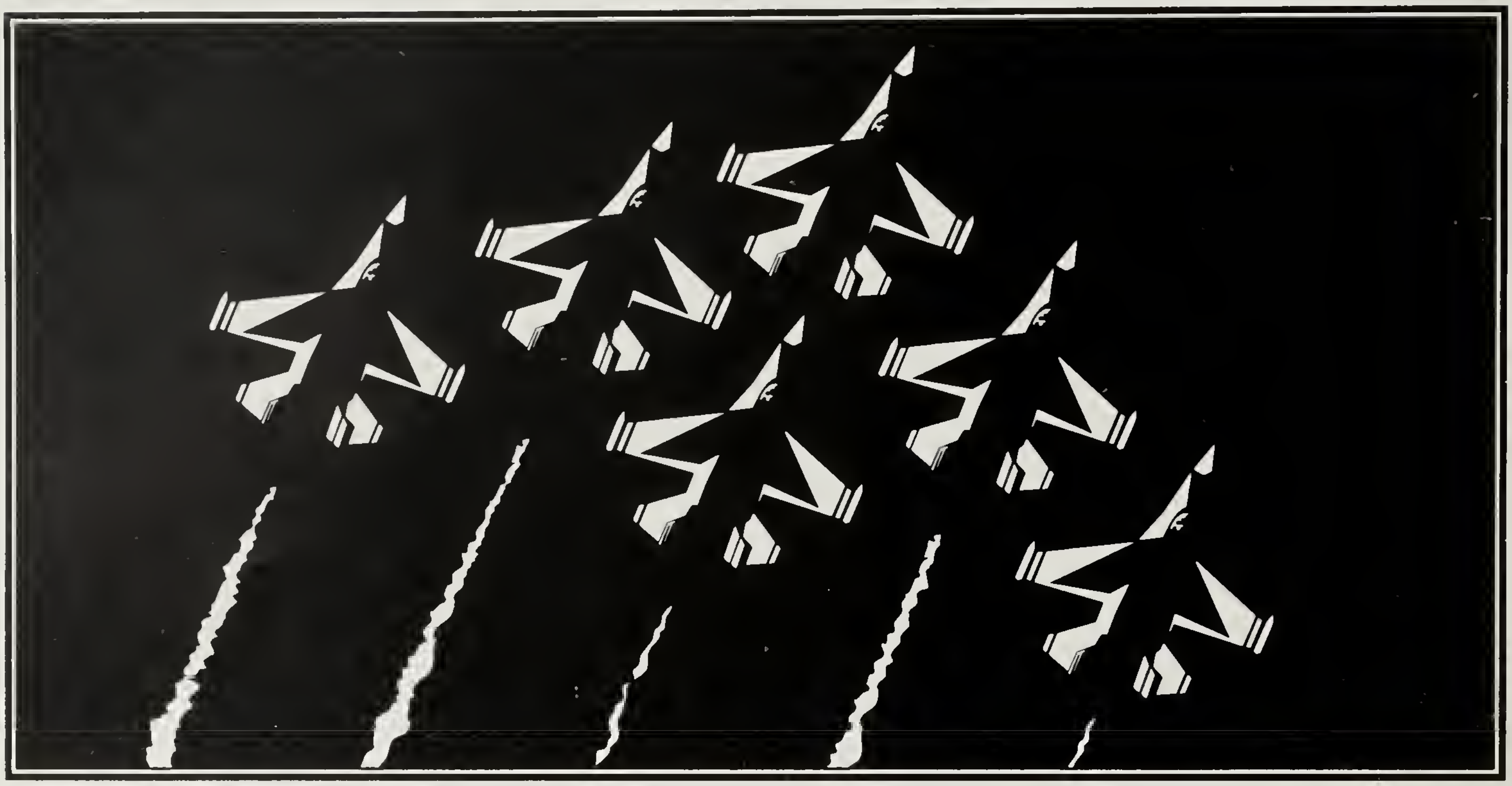

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RESOLVED: That MSMS reevaluate its policy of dues increases for three-year periods, and consider dues increases, if necessary, be done incrementally each year; and be it further

RESOLVED: That the MSMS Strategic Planning Committee reevaluate the validity and necessity of current MSMS spending programs.

- **60-91A**

Physician Information on Late Reports.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS work with the Michigan Hospital Association to develop and implement mechanisms to inform physicians of medical reports filed after a patient is discharged.

- **61-91A**

Malpractice Mediation II.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS urge the Michigan Supreme Court to amend MCR 2.403 to provide that health care professionals selected as mediators shall receive the full medical record for review at least fourteen days prior to mediation; and be it further

RESOLVED: That enforceable financial sanctions be imposed against attorneys who do not provide the full medical record in a timely manner.

- **62-91A**

Malpractice Mediation.

John A. Rupke, MD, for the Hospital Medical Staff Section

No Action.

- **63-91A**

Renew AMA International Medical Graduates' Advisory Committee.

Allan C. D. Brown, MD, for the Section for International Medical Graduates.

Adopted.

RESOLVED: That MSMS request the AMA Board of Trustees to renew its Advisory Committee for International Graduates for at least two more years to give the Committee an opportunity to complete its work.

- **64-91A**

Payment of Physician's Services for Patients in Observational or Short Stay Units.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

MSMS presidents — past, present and future — take a moment to gather for a photo. Shown (l to r) are: Thomas C. Payne, MD, MSMS president-elect; Robert D. Burton, MD, president; and Susan H. Adelman, MD, immediate-past president.

RESOLVED: That MSMS seek reimbursement from all third party payors for physician's services when patients are appropriately managed in short stay units or on observatory status and that the Michigan Delegation to the AMA request the AMA to take the appropriate action to obtain payment for these services from Medicare.

- **65-91A**

Elimination of Pre-Procedural Review.

John A. Rupke, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS seek elimination of pre-procedural and pre-admission review by all third party payors in Michigan; and be it further

RESOLVED: That the Michigan Delegation to the AMA urge the AMA to seek immediate elimination of the Medicare pre-procedural and pre-admission review.

- **66-91A**

Medical Student Section Communications.

Rebecca Brienza, MSU, for the Medical Student Section

Adopted.

RESOLVED: That MSMS develop a newsletter specifically for the Medical Student Section, which reflects the unique concerns and interest of medical students; and be it further

RESOLVED: That the Medical Student Section newsletter be published three or four times a year, with assistance from members of each medical school and contain information about medical student activities at each medical school; and be it further

RESOLVED: That the Medical Student Section newsletter contain membership recruitment information and be distributed to non-member medical students as well.

- **67-91A**

Physician Appointments to Health Care Committees.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS request the AMA to appoint only those physicians who are members of both the AMA and their state medical society to health policy committees for private and governmental studies; and be it further

RESOLVED: That MSMS adopt a similar policy.

- **68-91A**

Medical Practice Standards Set by Insurance Companies.

Steven E. Olchowski, MD, for the Wayne County Medical Society Delegation

No Action.

- **69-91A**

Rejection of Continuing Medical Education (CME).

Joel Kriegel, MD, Macomb County

Adopted as Amended.

RESOLVED: That MSMS encourage providers of CME programs to offer their courses at a fee equal to or less than the estimated costs; and be it further

RESOLVED: That MSMS recommend the Accreditation Council on Continuing Medical Education take similar action.

- **70-91A**

Student Loan Endowment Fund.

Sandra Brinker, WSU, for the Medical Student Section

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Referred to the Board for Study.

RESOLVED: That MSMS create a Student Loan Endowment Fund, and whose funds would be used for the sole purpose of extending low interest loans to Michigan medical students, who would repay the loan upon completion of their medical training, thus sustaining the fund; and be it further

RESOLVED: That MSMS place qualifications on recipients of the Student Loan Endowment Fund including but limited to the following:

1. Must be a member of MSMS;
2. Must be a student in good standing currently enrolled at the Michigan State University, College of Human Medicine; the University of Michigan Medical School; or the Wayne State University School of Medicine;
3. Preference to students who have no other source of financial aid, enabling more students to take advantage of financial aid programs;
4. Preference to students who show financial need according to the student's Financial Aid Form (FAF) or Family Financial Statements (FFS) on file at the medical school's Office of Financial Aid;
5. Adaptions of payback terms for students who agree to remain in the State of Michigan following their medical training, allowing either lower interest rates or longer deferment periods for those physicians;
6. Similar adaptions may be allowed for students who choose primary care fields for their residency training programs.

• 71-91A

Subrogation Lien Rights of Blue Cross Blue Shield of Michigan in Medical Malpractice Cases.

Robert E. Paxton, MD, Immediate Past President

Adopted.

RESOLVED: That MSMS introduce legislation banning subrogation lien rights by third party health insurers and give full support towards successful passage of such legislation.

• 72-91A

Opposition to Discriminatory Practices.

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Substitute Resolution (in lieu of 72-91A and 78-91A). Adopted.

RESOLVED: That MSMS reaffirm its policy supporting federal legislation that bans discrimination in licensure, licensure by endorsement, jobs, promotions, hospital privileges, reimbursement, residency medical staff and academic appointments, professional society memberships, financial aid and board certification solely on the basis of being a graduate of a foreign medical school.

• 73-91A

Develop Michigan Externship Programs for the International Medical Graduates (IMGs)

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Referred to the Board for Study.

RESOLVED: That MSMS explore ways to work with interested groups to provide externship programs for international medical graduates so that they can be accepted into training programs.

• 74-91A

Monthly Column in JAMA for International Medical Graduates (IMGs).

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Adopted as Amended.

RESOLVED: That MSMS request the AMA Advisory Committee on IMG's to encourage the Editorial Board of JAMA to publish a monthly column on issues of interest to IMG's.

• 75-91A

MSMS Aid to International Medical Graduates (IMGs) for Residency Placement Following Match Day.

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Adopted as Amended.

RESOLVED: That MSMS develop a program to assist nonmatched prospective residents in obtaining a residency placement in unfilled Michigan positions following Match Day.

• 76-91A

Residency Program Prejudiced Against Applicant with Ethnic Names.

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Adopted as Amended.

RESOLVED: That MSMS encourage directors of Michigan based residency programs to select residents on the basis of merit and without consideration of an ethnic name as a negative factor; and be it further

RESOLVED: That the Michigan Delegation to the AMA recommend that the AMA encourage directors of national residency programs to select residents on the basis of merit and without consideration of an ethnic name as a negative factor.

• 77-91A

Study of AMA Section for International Medical Graduates (IMGs).

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Adopted as Amended.

RESOLVED: That MSMS ask the AMA Advisory Committee for IMGs to explore the development of a Section for IMGs at the AMA level; and be it further

RESOLVED: That the Michigan Delegation to the AMA support the efforts of the AMA Advisory Committee for IMGs to establish a Section for International Medical Graduates at the AMA level.

• 78-91A

AMA to Expedite Equality in Licensure.

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Substitute Resolution (in lieu of 72-91A and 78-91A). Adopted. See Resolution 72-91A.

• 79-91A

MSMS Representation of Academic Physicians.

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Adopted as Amended.

RESOLVED: That MSMS explore ways to provide an open forum to discuss the needs and concerns of academic physicians under the umbrella of the Michigan State Medical Society.

• 80-91A

Comparative Fee Study.

Donald C. Camp, MD, for the Michigan Society of General Surgeons

Disapproved.

• 81-91A

True Peer Review.

Robert C. Packer, MD, Muskegon County

Adopted.

RESOLVED: That MSMS ask the AMA to request Health Care Financing Administration (HCFA) to require the Professional Review Organizations (PRO's) to utilize specialty specific reviewers to make all final determinations of appropriateness and quality of care; and be it further

RESOLVED: That if the PRO has no reviewer qualified to make a determination in a specific case, then it must obtain the services of a non-PRO physician on a fee-for-service or contractual arrangement to provide "true peer review."

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• 82-91A

Medical Research Impact on the Cost of Medical Care.

Owen M. Berow, MD, Kalamazoo County

Disapproved.

• 83-91A

Uniform Licensing of Physicians.

Michael D. Chafty, MD, for the Resident Physician Section

Referred to the Board for Study.

RESOLVED: That MSMS request the Board of Medicine to develop criteria for uniform licensing of all physicians in the State of Michigan; and be it further

RESOLVED: That MSMS support legislative redress to ensure uniform licensing requirements of allopathic and osteopathic physicians in Michigan.

• 84-91A

L-glutamic Acid.

Michael J. Parks, MD, VanBuren County

Adopted as Amended.

RESOLVED: That MSMS ask the AMA to encourage all appropriate regulatory agencies including the Food and Drug Administration to make labeling mandatory on all foods containing even small amounts of the man-made form of L-glutamic acids so the individuals wanting to avoid this substance may do so.

• 85-91A

Philip Morris Bill of Rights Tour.

John R. Maurer, MD, for the Michigan Society of Internal Medicine

Adopted as Amended.

RESOLVED: That MSMS join other groups, including the American Lung Association and the American Society of Internal Medicine, in coordinating a campaign to take place at the time the exhibit visits Michigan. This campaign should be primarily an informational campaign highlighting the serious health consequences of tobacco use.

• 86-91A

Government Mandated Fee Schedules for Automobile No-Fault Insurance.

Omero Iung, MD, and D. Bonta Hiscoe, MD, Ingham County, for Floyd G. Goodman, MD

Adopted.

RESOLVED: That MSMS request the Michigan Legislature to refrain from enacting laws which would require the use of a government-mandated medical fee schedule or a government-mandated managed health care system or other restrictions or limitations on medical benefits in automobile no-fault; and be it further

RESOLVED: That MSMS present a copy of this resolution to the Michigan Senate, the Michigan House of Representatives and to Governor John Engler.

• 87-91A

Workers Compensation Fee Schedule.

Omero Iung, MD, and D. Bonta Hiscoe, MD, Ingham County, for Floyd G. Goodman, MD

Adopted.

RESOLVED: That MSMS arrange to provide input on Workers Compensation fee schedules and disputes of the same from this point forward; and be it further

RESOLVED: That MSMS request the Michigan Legislature to act promptly to enact legislation which will eliminate the requirement for the Workers Compensation government-created medical fee schedule from the law.

• 88-91A

Blue Cross Blue Shield of Michigan (BCBSM) Identification Cards.

Omero Iung, MD, and D. Bonta Hiscoe, MD, Ingham County, for Floyd G. Goodman, MD

Adopted as Amended.

RESOLVED: That MSMS seek legislation to: (1) require that subscribers covered under an administrative services only (ASO) arrangement have separate BCBSM identification cards; (2) require that separate physician participating agreements be established for ASO business; and (3) to permit employees of ASO customers to stipulate to direct payment to their physicians regardless of whether they have signed a participating agreement.

• 89-91A

Medicare Carrier.

Omero Iung, MD, and D. Bonta Hiscoe, MD, Ingham County, for Floyd G. Goodman, MD

Substitute Resolution (in lieu of 89-91A and 93-91A). Adopted.

RESOLVED: That MSMS investigate alternative carriers through which physicians can bill Medicare.

• 90-91A

Blue Cross Blue Shield of Michigan (BCBSM) Provider Class Plan.

Omero Iung, MD, and D. Bonta Hiscoe, MD, Ingham County, for Floyd G. Goodman, MD

Referred to the Board for Study.

RESOLVED: That MSMS request the Michigan Insurance Commissioner in cooperation with the Michigan Legislature, to conduct a comprehensive review of BCBSM consistent with the purposes described in this resolution; and be if further

RESOLVED: That MSMS request the Michigan Insurance Bureau and the Michigan Legislature to take affirmative steps to ensure that BCBSM Provider Class Plan for physicians shall provide for reasonable physician reimbursement which is comparable to that being paid by BCBS and other third party plans in surrounding states; and be it further

RESOLVED: That MSMS send a copy of this resolution to the Insurance Commissioner, the Michigan Senate, the Michigan House of Representatives, and to Governor John Engler.

• 91-91A

Blue Cross Blue Shield of Michigan (BCBSM) Claims Appeals Process.

Omero Iung, MD, and D. Bonta Hiscoe MD, Ingham County, for Floyd G. Goodman, MD

Referred to the Board for Study.

RESOLVED: That MSMS request the Michigan Legislature to act expeditiously to enact legislation which will guarantee due process and equal protection for physicians and will affirmatively prohibit BCBSM from engaging in these violations of physicians' rights in the internal claims appeal process, the Physician Retrospective Profiling Program, the Physician Participation Agreement and the prepayment review program for BCBSM; and be it further

RESOLVED: That MSMS submit a copy of this document to the Michigan Senate, Michigan House of Representatives, and to Governor John Engler.

• 92-91A

Repeal of PA 350Section 401(6) and Section 502(1)(a) and (b).

William G. Tucker, MD, Lapeer County

No Action (Withdrawn).

• 93-91A

Medicare Intermediary.

Joel Kriegel, MD, Macomb County

Substitute Resolution (in lieu of 89-91A and 93-91A). Adopted. See Resolution 89-91A.

• 94-91A

Divestment of Financial Holdings in Tobacco Companies.

Sandra Brinker, WSU, for Michael Stack and Jay Fisher, for the Medical Student Section

Adopted as Amended.

RESOLVED: That MSMS when feasible refrain from making financial investments in mutual funds with tobacco holdings; nor make future investments in tobacco related companies.

• 95-91A

Medicaid Reimbursement.

Thomas A. Egleston, MD, Saginaw County

No Action.

• 96-91A

Medicaid Reimbursement.

John Maurer, MD, for the Michigan Society of Internal Medicine

Disapproved.

• 97-91A

Medicare Durable Medical Goods Prescribing.

David M. C. Hislop, MD, St. Clair County

Disapproved.

• 98-91A

PA 350 and the Mandatory Assignment Provision.

David M. C. Hislop, MD, St. Clair County

Substitute Resolution (in lieu of 20-91A and 98-91A). Adopted. See Resolution 20-91A.

• 99-91A

Medicaid Reimbursement.

David M. C. Hislop, MD, St. Clair County

Adopted.

RESOLVED: That MSMS oppose all Medicaid cuts in reimbursement and that payments be increased to a level to cover physician and hospital costs.

• 100-91A

Medicaid Payments to Physicians.

Donald Paarlberg, MD, Branch County, for Jeffery C. Custer, MD

No Action.

• 101-91A

Peer Review Organization (PRO) Sanctions.

Gerald H. Mandell, MD, Wayne County

Adopted as Amended.

RESOLVED: That MSMS vigorously pursue with appropriate PRO's (1) the careful definition of an adverse event, (2) the identification of whether the event is avoidable or unavoidable, or a recognized complication of diagnosis or treatment, and (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior, and that the Michigan Delegation to the AMA request the AMA to take similar action; and be it further

RESOLVED: That in the absence of evaluation and appropriate identification of "fault," the PRO be limited in its penalty against the attending physician.

• 102-91A

Preserving Manual Billings.

Samir Ragheb, MD, Macomb County

Adopted as Amended.

RESOLVED: That MSMS ask Blue Cross Blue Shield of Michigan (BCBSM), as the Medicare intermediary, and Health Care Financing Administration (HCFA) to preserve manual billing with no disincentives or punitive measurers; and be it further

RESOLVED: That MSMS submit a similar resolution preserving manual billing to the AMA House of Delegates so the AMA would ask HCFA to preserve manual billing on equal footing with computerized billing.

• 103-91A

MSMS Task Force on Access to Care.

Karl J. Edelmann, MD, for the Washtenaw County Medical Society

Referred to the Board for Study.

RESOLVED: That MSMS establish a task force to develop and promote policies regarding access to care for all Michigan citizens to address but not be limited to, liability concerns, use of ancillary medical personnel, including nurse practitioners and physicians assistants, rural and urban health care needs, reimbursement levels for public and private insurance, and coverage for those citizens not presently covered by any insurance.

• 104-91A

Do Not Resuscitate (DNR) Policy.

Manfred Marcus, MD, Washtenaw County

Referred to the Board for Study.

RESOLVED: That MSMS support legislation to promote universal documented discussion with the patients and/or family and/or appointed guardian, of the "do not resuscitate" option; and be it further

RESOLVED: That MSMS encourage its members to participate actively in educating themselves and their patients in the DNR option, living wills, etc.; and be it further

RESOLVED: That MSMS seek information as to the best devices to alert first responders that a DNR is in place and to be honored as such; and be it further

RESOLVED: That MSMS recommend the inclusion in the medical record of hospitalized patients and patients in extended care facilities to carry a document that states the patient's wishes regarding CPR, in the same vein, develop guidelines to allow patients to name a guardian to decide health care issues once they become unable to do so; and be it further

RESOLVED: That MSMS support as much antonomy as possible for the patient to decide when and how to withdraw life support, either directly or via a substituted judgment, the advisor being the physician instead of the legal system.

• 105-91A

HIV Testing in the Event of Accidental Exposure or Contamination.

Rhoda M. Powsner, MD, Washtenaw County

Substitute Resolution (in lieu of 12-91A and 105-91A). Adopted. See Resolution 12-91A.

• 106-91A

Opposition to a Radioactive Waste Site in Michigan.

Siavosh Varjavandi, MD, for the Genesee County Medical Society

No Action.

• 107-91A

The Need to Enact Strict Water Quality Protection Laws for Great Lakes Water Systems.

Siavosh Varjavandi, MD, for the Genesee County Medical Society

Adopted as Amended.

RESOLVED: That MSMS recognize the primary importance of Great Lakes water quality for the public health of the people of Michigan; and be it further

RESOLVED: That MSMS recognize the urgent need for further toxicology studies on the effect of Great Lakes contaminants on human populations; and be it further

RESOLVED: That MSMS urge the Michigan state government to promote appropriate action to stop the inflow of persistent toxic substances into the Great Lakes environment; and be it further

RESOLVED: That MSMS contact other state and provincial medical societies in the Great Lakes Basin and urge them to work in concert toward a less toxic Great Lakes Basin environment.

• 108-91A

Indemnify Michigan Physicians Against Liability for Care of the Indigent.

AppaRao Mukkamala, MD, for the Genesee County Medical Society

Adopted as Amended.

RESOLVED: That MSMS aggressively pursue passage of a law to indemnify physicians against malpractice suits when care has been provided to Medicaid patients; and be it further

RESOLVED: That MSMS ask the AMA to pursue passage of a similar law at the federal level.

- **109-91A**

Defining the Terms "Right to Health Care."

Ali Esfahani, MD, for the Genesee County Medical Society Delegation

No Action.

- **110-91A**

Invitation to Governor Engler to Explain to Communities Why the Private Sector Should Step in Where the State is Stepping Away from Responsibility.

Virgil Villarreal, MD, for the Genesee County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS invite Governor Engler and legislative leaders to explain to the full membership of MSMS what they expect the role of the private sector providers to be in the provision of health care to Michigan's recipients of Department of Social Services benefits, as well as those who have been removed from that list of recipients.

- **111-91A**

Proposed Public Relations Campaign in Opposition to Medicaid and General Assistance (GA) Medical Budget Cuts.

W. Archibald Piper, MD, for the Genesee County Medical Society Delegation

Disapproved.

- **112-91A**

Removal of Michigan Doctors Political Action Committee (MDPAC) Contribution Solicitation from Dues Statements.

Cyrus Farrehi, MD, Genesee County, for Lewis E. Simoni, MD

Adopted as Amended.

RESOLVED: That MSMS remove the MDPAC contribution from the total amount printed on the dues billing form, and that the MDPAC contribution be separately identified on the form.

- **113-91A**

Commending the Genesee County Medical Society on Its 150th Anniversary.

Vivian M. Lewis, MD, Genesee County

Adopted.

RESOLVED: That MSMS congratulate the Genesee County Medical Society for 150 years of activity on behalf of patients and the physicians who serve them; and be it further

RESOLVED: That MSMS ask the AMA to congratulate the Genesee County Medical Society on its 150th anniversary.

- **114-91A**

Medicaid Funding for Norplant Implants.

Sandra Brinker, WSU, for Michael Stack, for the Medical Student Section

Adopted as Amended.

RESOLVED: That MSMS pursue action through the Legislature and the Governor to provide pre-approved Medicaid funding for Norplant so that physicians can provide Norplant to their patients without having to subsidize the cost.

- **115-91A**

Therapeutic Optometric House Bill 4407.

Ali H. Sawaf, MD, for the Delta County Medical Society

Not Accepted as a Late Resolution.

- **116-91A**

Administrative Services Only Regulations.

Edwin M. Knights, MD, for the Michigan Society of Pathologists

Adopted as Amended.

RESOLVED: That MSMS petition the Michigan Insurance Commissioner to review Premier PLUS, and to make a determination regarding the applicability of state laws governing PPOs, PA 350 of 1980 and the Blue Cross Blue Shield Physicians and Professional Providers Participating Agreement on BCBSM's administrative services only business; and be it further

RESOLVED: That MSMS conduct legal research about the implications of Employee Retirement Income Security Act (ERISA), the federal law governing self-insured benefit plans, on physician relationships with BCBSM and other administrators of self-insured benefit plans; and be it further

RESOLVED: That MSMS communicate with the Governor, the State Legislature and the Congressional Delegation regarding the impact of federal pre-emption of the state's efforts to regulate health care coverage in Michigan; and be it further

RESOLVED: That the Michigan Delegation to the AMA request the AMA to seek amendments to ERISA that would remove the federal pre-emption of state regulation of self-funded health benefit plans.

- **117-91A**

Prescription for Androgenic Anabolic Steroids.

Angel Farina, MD, Wayne County

Adopted.

RESOLVED: That MSMS work with the proper agencies to modify the requirements for the prescribing of androgenic anabolic steroids to achieve a reasonable balance between the positive consequences that this law will have and the objectionable effects of its present regimentation on patients, physicians and pharmacists and bureaucracy in the State of Michigan; and be it further

RESOLVED: That this is done in a prompt and effective manner to obtain favorable results in a reasonable time frame.

- **118-91A**

Nathan Davis Award.

Doctors Huldin, Margulies, Powsner, Smith and Edelmann from the Outstate Caucus

Adopted as Amended.

RESOLVED: That the MSMS ask the AMA House of Delegates to express concern that the Nathan Davis Award is presented in the name of the AMA but without representing the will of the AMA House of Delegates nor the sentiment of the AMA members; and be it further

RESOLVED: That the process of selection of the Nathan Davis Awardee be widely disseminated to the members of the AMA House of Delegates for review.

State Representative Dave Camp (R-Midland), addresses delegates during a luncheon sponsored by the Michigan Doctors Political Action Committee.

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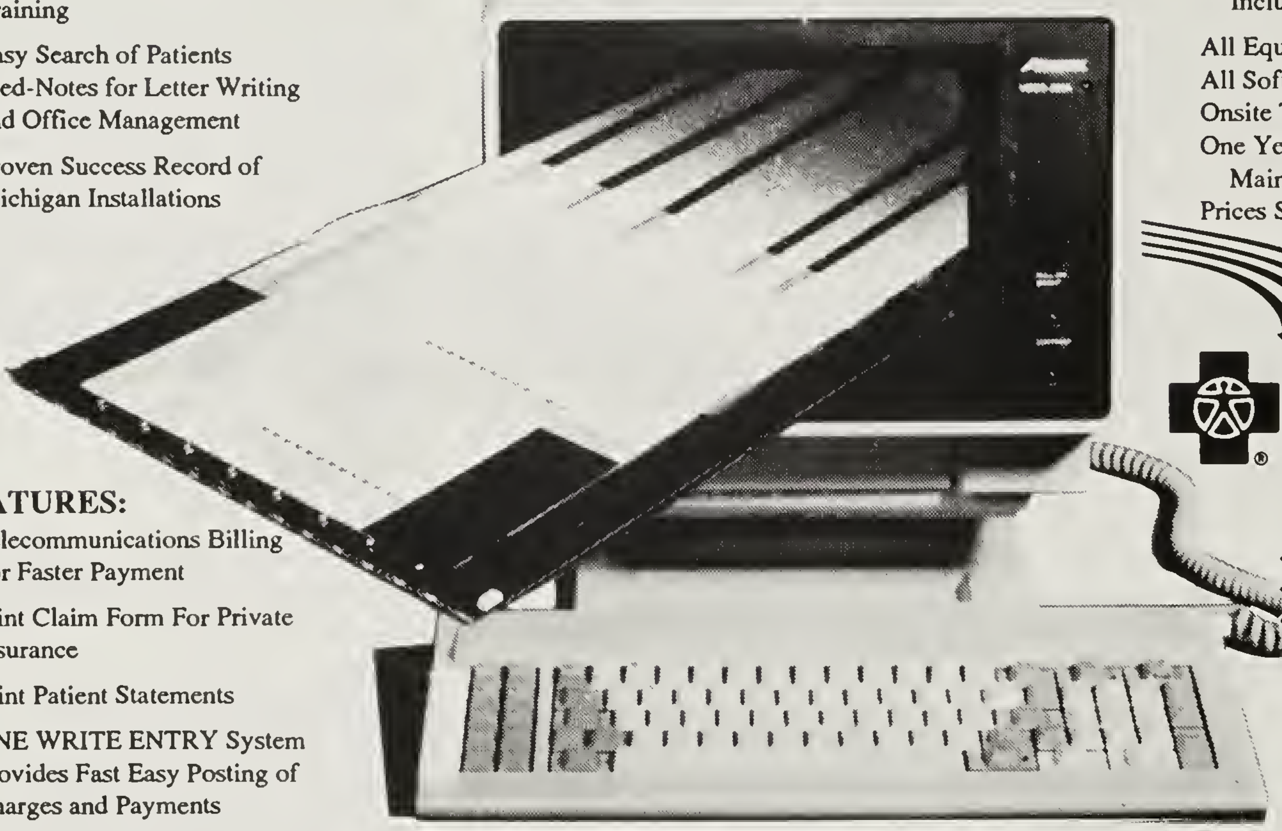

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Special Memberships

LIFE MEMBERSHIPS

Members who have maintained an active membership in good standing for 25 years in any one or more constituent state societies of the American Medical Association with any five years in Michigan.

Calhoun – Anne F. Norgan, MD
Genesee – Theodore J. Lukens, MD; Walter Z. Rundles, MD
Ingham – Eugene E. Bleil, MD; Jerome F. Cordes, MD
Ionia-Montcalm – Joseph Kopchick, MD
Iosco-Arenac – William F. Kutsche, MD
Isabella-Clare – Ray M. Chamberlain, MD
Kalamazoo – William D. Harrelson, MD
Kent – George E. Braunschneider, MD; Austin E. Lamberts, MD; Nanette Scheinder-Dice, MD
Livingston – Karol J. Granowski, MD; Phillip E. Schmitt, MD
Ludington – Robert R. Garneau, MD
Monroe – John W. Freud, MD; Gerald P. Lammers, MD
Northern Michigan – L. Jerome Fink, MD
Oakland – Samuel J. Behrman, MD; J. Frederic Johnson, MD; Julius Rutzky, MD; Francis M. Sheridan, MD; Edward M. Stempel, MD; Kenneth N. Trader, MD
St. Clair – Anthony C. Gholz, MD
Saginaw – Ronald G. Hines, MD
Shiawassee – Eugene S. Austin, MD
Van Buren – Adelbert L. Stagg, MD
Washtenaw – Catherine J. Caroll, MD; Fred Holtz, MD; Charles F. Krausse, MD; Beverly C. Payne, MD
Wayne – Stanley L. Barton, MD; Abraham H. Grant, MD; George H. Klutke, MD; John M. Lesesne, MD; Kenneth E. Maptletoft, MD; Frank R. Markey, MD; George E. McKeever, MD; Joseph M. McNamara, MD; Michael J. Michael, MD; Benjamin Mihay, MD; Joseph D. Picard, MD; James M. Ryan, MD; Robert L. Schaefer, MD; Jose M. Siero, MD; Joseph C. Watts, MD; Delford G. Williams, Jr., MD
Wexford-Missaukee – Arno A. Whipple, MD

RETIRED MEMBERSHIPS

Members who have maintained membership for five years in the component medical socity and retired from active practice.

Bay – Charles S. Rogers, MD
Berrien – Wilhelm K. Rock, MD
Calhoun – James D. Kiess, MD; Vance B. Lancaster, MD; Carl E. Powell, MD; Roman B. Zaplitny, MD;
Chippewa-Mackinac – Dale T. Scott, MD
Genesee – Robert L. Clark, MD; Carroll J. LaVielle, MD; Marjorie H. Otero, MD
Grand Traverse – Lee W. Hawkins, MD; Creighton A. Wagener, MD
Gratiot – William J. Roth, MD
Hillsdale – Charles T. Bear, MD
Ingham – Thomas C. Baker, MD; Ralph G. Carlson, MD; Robert E. Landick, MD; Harry J. Loughrin, MD; George D. Stilwill, MD; C. Carl West, MD
Ionia-Montcalm – Robert O. Smith, MD
Iosco-Arenac – Oscar P. Koltay, MD; Marta Szego-Koltay, MD
Jackson – Ralph A. Muhick, MD; Harold L. Oster, MD; Phillip A. Riely, MD; Leland D. Schaeffer, MD

Three individuals were presented with Presidential Citations for their efforts in creating the Senior Courtesy Card Program in Midland. Shown holding their citations are: J. Christopher Hough, MD (second from left); Robert S. Brown, MD, (middle); and Estelle Weismiller, MPH. Also shown are James G. O'Brien, MD, (far left), chairman of the MSMS Committee on Aging, and Susan H. Adelman, MD, (far right), MSMS president.

Kalamazoo – Kenneth J. Betten, MD; Frederick L. Clement, MD; Michael Graf, MD; Douglass A. Haddock, MD; John W. Hendrix, MD; John L. Kihm, MD; James W. Loynd, MD; Robert M. Nicholson, MD; Ervin Novak, MD; Clarence B. Nyce, MD; George L. Royer, MD
Kent – Harvey J. Bratt, MD; Marvin Bonzalaar, MD; R. Jack Chase, MD; Thomas B. Davis, MD; Gerben Dykstra, MD; James R. Glessner, MD; Ramon B. Lang, MD; Joseph D. Mann, MD; Robert B. Marshall, MD; Theodore P. Miller, MD; Donald C. Schek, MD; Martin Sharda, MD; Paul G. Theodore, MD; Richard t. Upton, MD; Robert A. Vander Ploeg, MD; Kornelius Van Goor, MD
Lapeer – Charles E. Conaway, MD; William C. Heitsch, MD
Lenawee – Carlton L. Cook, MD; Eleanor M. Parshall, MD
Livingston – Reginald W. Phillips, MD
Macomb – William P. Curtiss, MD; Herbert F. Friedman, MD; Miroslav Kollar, MD
Mason – Gerry L. Mayer, MD
Mecosta-Oceola-Lake – Earl W. Williams, MD
Midland – Raymond C. Bush, MD; Dale J. Ducommun, MD; E. Michael McGowan, MD; Harry O. Westphal, MD
Muskegon – Charles L. Adams, MD; George A. Voikos, MD
Northern Michigan – R. K. Homsi, MD; David N. Mikhail, MD; Jack R. Postle, MD; William L. Waters, MD; Richard D. Watkins, MD
Oakland – Mildred A. Axelrod, MD; Max J. Garber, MD; Sidney J. Hillenberg, MD; Antoine L. Joseph, MD; Bruce A. Kresge, MD; Henry Krystal, MD; Donald W. Martin, MD; Richard K. Meils, MD; Roger B. Nelson, MD; William H. Peirce, MD; Kenneth I. Ranney, MD; Glenn A. Sanford, MD; Ronald A. Selbst, MD; Stanko Stanisavljevic, MD; Donald J. Trumpour, MD
St. Clair – Armin T. Franke, MD; Jeremy Webster, MD
St. Joseph – Robert H. Evans, MD
Saginaw – William T. Rice, MD
Shiawassee – Norman F. Bach, MD; John R. Hofstra, MD; Phillip J. Moore, MD
Washtenaw – Walter G. Brovins, MD; Eugene F. Claeys, MD; Robert I. Goldsmith, MD; Hugo Quiroz, MD; Ruth H. Strang, MD; J. Reimer Wolter, MD
Wayne – Leonard C. Alexander, MD; Eugene C. Anderson, MD; Jacob E. Briski, MD; John E. Brisson, MD; Joseph Catalono, MD; Ned I. Chalat, MD; Barbara M. Chapper, MD; Mary E. Conroy, MD; Joseph A. Cortez, MD; Margaret R. Dietz, MD; Leonard L. DiLella, MD;John F. Fea, MD; Frederic C. Henderson, MD; Raymond D. Hill, MD; Frank Lee, MD; Biresh C. Mahanti, MD; Jasper E. McLaurin, MD; Larry J. McNichol, MD; Leonard W. Melander, MD; Frances E. Noe, MD; Peter Palmer, MD; Robert O. Reisig, MD; Robert M. Reynolds, MD; Richard A. Rideout, MD; Ernst A. Rodin, MD; Coleman J. Rottenberg, MD; Ernst C. Schultz, Jr., MD; Douglas H. Smith, MD; Carols S. Sosa, MD; Robert G. Wiencek, MD
Wexford-Missaukee – Robert F. Barnett, MD

Plessner Award

This award is presented by the MSMS Board of Directors to a rural physician who "best exemplifies the practice and ethics of a rual country practitioner." This year's recipient was:

Duane L. Water, MD, Manistique

Fifty-Year Awards

Fifty-year awards were presented to the following:

Ellis W. Adams, MD, Boynton Beach, FL
William Appel, MD, Tacoma, WA
Morris J. Arnkoff, MD, Southfield, MI
Francis F. Baker, MD, Mount Clemens, MI
Winona M. Barrows, MD, Kalamazoo, MI
Jere M. Bauer, MD, Ann Arbor, MI
William Beierwaltes, MD, Grosse Pointe, MI
Leonard J. Birndorf, MD, Lathrup Village, MI
Robert J. Bloor, MD, Pueblo West, CO
Jack L. Boyd, MD, Traverse City, MI
Robert W. Brown, MD, Battle Creek, MI
Herman R. Burkardt, MD, Menominee, MI
William J. Butler, MD, Kalamazoo, MI
Lawrence A. Cantow, MD, San Diego, CA
Hugh T. Caumartin, MD, Saginaw, MI
William Cayce, MD, Grand Rapids, MI
Mey-En Chen, MD, Grand Rapids, MI
Maynard M. Conrad, MD, Kalamazoo, MI

Thirty-one Michigan physicians were presented an award for 50 years of service.

Paul F. Cooper, MD, Kalamazoo, MI
Thomas A. Cresswell, MD, Saginaw, MI
F. C. Cretsinger, MD, Kalamazoo, MI
Dean T. Culver, MD, Coldwater, MI
Nan Denholm-Wolcott, MD, Delray Beach, FL
Z. Dickinson, MD, Laguna Hills, CA
Luebert Docter, MD, Grand Rapids, MI
Donald J. Drolett, MD, East Lansing, MI
Edward F. Eldredge, MD, Charlevoix, MI
Zachary F. Endress, MD, Bloomfield Hills, MI
Donald D. Finlayson, MD, Brimley, MI
Max A. Finton, MD, Northport, MI
Arthur L. Foley, MD, Eugene, OR
Morton L. Freier, MD, Birmingham, MI
David Friedman, MD, Farmington Hills, MI
H. Harvey Gass, MD, Birmingham, MI
Alex Gaynor, MD, Southfield, MI
Douglas H. Geise, MD, Muskegon, MI
Maxwell M. Goodman, MD, Oak Park, MI
James H. Graves, MD, Corunna, MI
Frank S. Greenslit, MD, Dearborn Heights, MI
John N. Grekin, MD, Southfield, MI
Eugenia E. Gurskis, MD, Union Lake, MI
Meyer A. Gutterman, MD, Southfield, MI
Hilda A. Habenicht, MD, Jackson, MI
Charles R. Haberlein, MD, Traverse City, MI
Curtis M. Hanson, MD, Kalamazoo, MI
Gordon R. Harrod, MD, Grand Ledge, MI
Aloysius J. Hegener, MD, Petoskey, MI
William A. Henkin, MD, Birmingham, MI
Arthur R. Hummel, MD, Lincoln, MI
Eli J. Igna, MD, Sun City West, AZ
Robert G. Jaedecke, MD, Green Valley, AZ
S. Newton Kelso, MD, Monroe, MI
Edward F. Kickham, MD, Saginaw, MI
John R. King, MD, Monroe, MI
Joyce W. Kingsley, MD, Grosse Pointe, MI
Michael J. Lahood, MD, Southfield, MI
Austin E. Lamberts, MD, Grand Rapids, MI
Francis W. Lanard, MD, Bloomfield Hills, MI
Ernst F. Lang, MD, Grosse Pointe, MI
Jack Lapides, MD, Ann Arbor, MI
Wesley G. Logan, MD, Hastings, MI
John E. Maley, MD, Whitmore Lake, MI
Frederick J. Margolis, MD, Kalamazoo, MI
William P. Marshall, MD, Scottsdale, AZ
Mason S. Maynard, MD, Englewood, FL
Dirk R. Mouw, MD, Grand Rapids, MI
Percy J. Murphy, MD, Calumet, MI
William C. Noble, MD, Farmington Hills, MI
Stanley P. Olesky, MD, Escondido, CA
Charles B. Overbey, MD, Kalamazoo, MI
Edwin O. Pearson, MD, Highland Beach, FL
Philip S. Peven, MD, West Bloomfield, MI
Richard W. Pomeroy, MD, East Lansing, MI
William P. Purfield, MD, Manchester, MI
Edward L. Quinn, MD, Birmingham, MI
Louis A. Ravitz, MD, Southfield, MI
W. Earl Redfern, MD, Atlanta, MI
M. Andrew Sapala, MD, Albion, MI
Allen Saunders, MD, Ann Arbor, MI
Henry Schlesinger, MD, West Bloomfield, MI
Frank R. Schultz, MD, Chesaning, MI
Arthur G. Seski, MD, Grosse Pointe, MI
I. Walters Silver, MD, Detroit, MI
Joseph Slusky, MD, Bloomfield Hills, MI
Leonard H. Stern, MD, Ortonville, MI
Lawrence L. Stocker, MD, West Bloomfield, MI
Irene Suen-Yip, MD, Port Charlotte, FL
Hugh L. Sulfridge, MD, Saginaw, MI
Henry C. Tellman, MD, Muskegon, MI
Richard L. Thirlby, MD, Traverse City, MI
William H. Tyler, MD, Sun City, AZ
Henry J. Vandenburg, MD, Grosse Pointe, MI
Michael A. Wainstock, MD, Bloomfield Hills, MI
John H. Weidner, MD, Birmingham, MI
Robert G. Wetterstrom, MD, Lehigh Acres, FL
Bernard C. Wildgen, MD, Muskegon, MI
Edward V. Williams, MD, Muskegon Heights, MI
Irvin A. Wilner, MD, Southfield, MI
Richard E. Wunsch, MD, Traverse City, MI
Jerome A. Yared, MD, Grand Rapids, MI
Chris J. Zarafonetis, MD, Ann Arbor, MI

Flag Award

This award was presented to the following president of a statewide non-medical organization:

David R. Rovner, MD, President, Michigan Affiliate, Michigan Diabetes Association, East Lansing

National Presidents Awards

This award was presented to the following for their service as presidents of national medical organizations:

Elie D. Aboulafia, MD, President, United States Section, International College of Surgeons, Farmington Hills, MI

John A. Anderson, MD, Presidnet, American Academy of Allergy and Immunology, Northville, MI

Elissa P. Benedek, MD, President, American Psychiatric Association, Ann Arbor, MI

Robert H. Burke, MD, President, American College of Oral and Maxillofcial Surgeons, Ann Arbor, MI

John L. Glover, MD, President, Midwest Surgical Association, Royal Oak, MI

Kamran S. Moghissi, MD, President, American Fertility Society, Detroit, MI

Joel R. Saper, MD, President, American Association for the Study of Headache, Ann Arbor, MI

Elias A. Shaptini, MD, President, American College of Occupational Medicine, Detroit, MI

Jeremiah G. Turcotte, MD, President, Central Surgical Association, Ann Arbor, MI

Presidential Citation

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to the following for efforts in creating the Senior Courtesy Card Program:

Robert S. Brown, MD, Midland
J. Christopher Hough, MD, Midland
Estelle Weismiller, MPH, Midland County Council on Aging

AMA House of Delegates Certificate of Appreciation

This award, presented to physicians for their past service on the Michigan Delegation to the American Medical Association, was presented to:

Richard L. Rapport, MD, Flint

Elections

The 1991 House of Delegates elected the following MSMS officers, directors, delegates and alternates to the American Medical Association.

Officers (to the 1992 Annual Session)

President .... Robert D. Burton, MD, Grand Rapids
President-elect ...... Thomas C. Payne, MD, East Lansing
Secretary ..... Thomas R. Berglund, MD, Portage
Assistant Secretary ...... Earl C. Moehn, MD, Mt. Clemens
Treasurer .... Billy Ben Baumann, MD, Pontiac
Assistant Treasurer .... B. David Wilson, MD, Kalamazoo
Speaker .... Robert D. Allaben, MD, Detroit
Vice-Speaker .. Gary D. Maynard, MD, Kalamazoo

District Directors (to the 1994 Annual Session)

1st .... Henry M. Domzalski, MD, Detroit
2nd Thomas D. Harris, MD, Jackson
3rd .... Lionel E. Dorfman, MD, Battle Creek
5th .... Willard S. Stawski, MD, Grand Rapids
9th .... John W. Hall, MD, Petoskey
11th .... Thomas E. Stone, MD, Muskegon
13th .... David H. Gilbert, MD, Laurium
15th ... Frederick V. Minkow, MD, Bloomfield Hills
15th .... Earl C. Moehn, MD, Mt. Clemens
15th ...... John H. McLaughlin, MD, Birmingham

Delegates to the AMA (to the 1993 Annual Session)

Susan Hershberg Adelman, MD, Southfield
Robert D. Burton, MD, Grand Rapids
Donald K. Crandall, MD, Muskegon
Fernando Gomez, MD, Royal Oak, (Resident)
Gerald H. Mandell, MD, Detroit
Robert E. Paxton, MD, Fremont
Thomas C. Payne, MD, East Lansing

Alternate Delegates to the AMA (in order of seniority to the 1993 Annual Session)

Robert W. Black, MD, Detroit
Cathy O. Blight, MD, Flint
Peter A. Duhamel, MD, Rochester
Willard S. Stawski, MD, Grand Rapids
Margaret R. Shearer, MD, Ann Arbor
Gilbert B. Bluhm, MD, Detroit
Gary D. Maynard, MD, Kalamazoo
Pino D. Colone, Flint (Student)

Billy Ben Baumann, MD, MSMS treasurer, (at podium), congratulates Richard L. Rapport, MD, Flint, recipient of the AMA House of Delegates Certificate of Appreciation.

Join Dr. Hanley.

"I think one of the greatest contributions of the AMA is its activities on behalf of the most vulnerable in our society, children.

"The AMA adolescent health program is a great benefit to physicians who practice adolescent medicine and to policy-makers. But there is so much more that needs to be done. The AMA deals with the seemingly countless number of issues confronting medicine. And because it does, it gives me a great feeling of hope about the future.

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Alan M. Mindlin, MD, Oakland
Robert C. Packer, MD, Muskegon
Joseph J. Weiss, MD, Wayne

Board Advisors:
Gilbert B. Bluhm, MD
Peter A. Duhamel, MD
Earl G. Moehn, MD

AMA Delegation Advisors:
Robert W. Black, MD
Donald K. Crandall, MD

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Rolland E. Bethards, MD, Ingham
C. Peter Fischer, MD, Washtenaw
Kenneth W. Gitlin, MD, Oakland
John P. Papp, MD, Kent
Virgilio G. Villarreal, MD, Genesee
Bernard J. Woodley, MD, Wayne

Board Advisors:
Carl F. Hammerstrom, MD
Charles C. Vincent, MD

AMA Delegation Advisors:
Cathy O. Blight, MD
Marguerite Shearer, MD

REFERENCE COMMITTEE C — INTERNAL AFFAIRS AND PUBLIC SERVICE

W. Archibald Piper, MD, Genesee, Chairman
Randall M. Johnson, MD, Marquette-Alger
Bruce T. Lessien, MD, Oakland
David B. Martin, MD, Grand Traverse-Leelanau-Benzie
Ivan C. Schatten, MD, Wayne
W. Mark Todd, MD, Kalamazoo
Michael A. Wozny, MD, Calhoun

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R. Jack Chase, MD
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AMA Delegation Advisor:
Thomas C. Payne, MD

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Ronald L. Jensen, MD, Saginaw
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Mitchell A. Rinek, MD, Ingham
Siavosh Varjavandi, MD, Genesee

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Louis E. Zako, MD

REFERENCE COMMITTEE E — PUBLIC HEALTH AND MISCELLANEOUS

Allen Silbergleit, MD, Chairman, MI Society of Thoracic and Cardiovascular Surgeons
R. John Bradfield, MD, Wayne
Rebecca S. Brienza, MSU, Medical Student Section
Michael D. Chafty, MD, Resident Physician Section
Clyde R. Flory, MD, Ingham
John M. MacKeigan, MD, Kent
AppaRao Mukkamala, MD, Genesee

Board Advisors:
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James L. Fenton, MD
David J. Millard, MD

AMA Delegation Advisors:
Busharat Ahmad, MD
John W. Hall, MD

COMMITTEE ON CREDENTIALS AND TELLERS

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Steven S. Bolton, MD, Oakland
Alfonso C. Ferreira, MD, Tuscola
Ann M. Minnema, MD, Kent

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Steven E. Newman, MD, Oakland, Chairman
R. Paul Clodfelder, MD, Kent
Angel Farina, MD, Wayne
Jack D. Gift, MD, Jackson
Thomas F. Higby, MD, Livingston
Samuel D. Indenbaum, MD, Wayne
Geoffrey A. Wardwell, MD, Kalamazoo

Ex-officio Members:
William E. Madigan
Richard D. Weber

AMA Delegation Advisor:
Willard S. Stawski, MD

COMMITTEE ON RULES AND ORDER OF BUSINESS

Reed K.Freidinger, MD, Northern Michigan, Chairman
Peter Aliferis, MD, Alpena
Jerry Drake, MD, Wayne
Sarla Puri, MD, Kent
William G. Tucker, MD, Lapeer

Board Advisor:
Thomas R. Berglund, MD

COMMITTEE ON WAYS AND MEANS

Robert C. Prophater, MD, Bay, Chairman
Warren E. Bontrager, MD, North Central
Arnold L. Brown, MD, Oakland
Richard P. Heuschele, MD, Saginaw
Dorothy M. Kahkonen, MD, Wayne
James K. Watkins, MD, Kent
David M. Woodliff, MD, Barry

Board Advisors:
Billy Ben Baumann, MD
David M. C. Hislop, MD
B. David Wilson, MD

MICHIGAN STATE MEDICAL SOCIETY
125 Years
New Reformation Dixieland Band

The New Reformation Dixieland Band was the featured entertainment at the Saturday evening Presidential Ball.

Delegates' Record of Attendance

May 3-5

	MEETING		
OFFICERS	1st	2nd	3rd
Speaker:			
Robert D. Allaben, MD	X	X	X
Vice-Speaker:			
Gary D. Maynard, MD	X	X	X
Secretary:			
Thomas R. Berglund, MD	X	X	X
DELEGATES AND ALTERNATES			
ALLEGAN:			
Van O. Keeler, MD	X	X	X
ALPENA-ALCONA-PRESQUE-ISLE			
Peter Aliferis, MD	X	X	X
BARRY:			
David M. Woodliff, MD	X	X	X
BAY:			
Paul L. Chan, MD	X	X	X
Robert C. Prophater, MD	X	X	X
James F. Stoddard, MD	-	-	-
BERRIEN:			
William C. Bock, MD	X	X	X
Frank H. Bunker, MD	X	X	X
Frederick H. Lindenfeld, MD	-	-	-
Frank Linn, MD	-	-	-
BRANCH:			
Donald Paarlberg, MD	-	-	-
CALHOUN:			
B. Douglas Campbell, MD	X	X	X
Robert W. Oakes, MD	X	X	X
M. R. Siddiqi, MD	X	-	-
Paul A. Walk, MD	X	X	X
Michael A. Wozny, MD	-	X	X
CASS:			
Boonchoo Chang, MD	X	X	X
CHIPPEWA-MACKINAC:			
Jack M. Pahn, MD	X	X	X
DELTA:			
Ali H. Sawaf, MD	-	-	-
Carol A. Krieg, MD	X	X	X
DICKINSON-IRON:			
Douglas L. Villa, MD	-	-	-
EATON:			
Sherman W. Horn, II, MD	X	X	X
GENESEE:			
Ali A. Esfahani, MD	-	-	-
Cyrus Farrehi, MD	-	-	-
George H. Greidinger, MD	X	X	X
Edwin H. Gullekson, MD	X	X	X
Vivian M. Lewis, MD	X	-	X
Sudarsan Misra, MD	-	-	X
AppaRao Mukkamala, MD	X	X	X
W. Archibald Piper, MD	X	X	X
Richard L. Rapport, MD	X	-	-
Robert W. Rosenbaum, MD	X	X	X
Frederick W. Sherrin, MD	-	X	-
Lewis E. Simoni, MD	X	X	X
Charles A. Thompson, MD	-	-	-
Allen F. Turcke, MD	X	X	-
Siavosh Varjavandi, MD	-	X	X
Virgilio G. Villarreal, MD	-	-	-
GOGEBIC:			
James M. Frank, MD	-	-	-
GRAND TRAVERSE-LEELANAU-BENZIE:			
Lawrence S. Loesel, MD	-	-	-
David B. Martin, MD	X	-	-
Kenneth H. Musson, MD	X	X	X
Edward J. Rutkowski, MD	-	X	-
GRATIOT:			
Ashok R. Sonnad, MD	-	-	-
HILLSDALE:			
William G. Keating, MD	-	-	-
HOUGHTON-BARAGA-KEWEENAW:			
Kenneth E. Rowe, MD	X	X	X
HURON:			
Edward E. Steinhardt, MD	X	X	X
INGHAM:			
Rolland E. Bethards, MD	X	X	-
Clyde R. Flory, MD	X	X	X
D. Bonta Hiscoe, MD	X	X	X
Donald H. Huldin, MD	X	X	X
Omero S. Iung, MD	X	X	X
David K. Johnson, MD	X	-	-
Martin F. Jones, MD	-	X	X
Marsha Milburn, MD	X	X	X
Mitchell A. Rinek, MD	X	-	X
IONIA-MONTCALM:			
Louis E. Sanford, MD	-	-	-
Doyle E. Calley, MD	X	X	X
IOSCO-ARENAC:			
Devendra K. Sharma, MD	-	X	X
Norman P. Payea, MD	X	-	-
ISABELLA-CLARE:			
S. Gay Freeman, MD	-	-	-
JACKSON:			
Jack D. Gift, MD	-	-	-
Bruce F. Knoll, MD	-	-	-
Parviz Samii, MD	-	-	-
KALAMAZOO:			
E. Joseph Alberding, MD	-	-	-
Owen M. Berow, MD	X	X	X
M. Joseph Bowler, MD	X	X	X
Charles F. Butler, MD	X	X	-
Richard T. Jefson, MD	-	-	-
James B. Kilway, MD	X	-	-
William J. Kube, MD	X	X	X
Gary D. Maynard, MD	X	X	X
David A. Milki, MD	X	X	-
W. Mark Todd, MD	X	X	X
Geoffrey A. Wardwell, MD	X	X	X
Janice L. Webinski, MD	X	X	X
KENT:			
Peter B. App, MD	-	-	-
John H. Beernick, MD	X	X	X
Marcus G. Beversluis, MD	X	X	X
R. Paul Clodfelder, MD	X	-	X
Douglas A. Edema, MD	X	-	-
Paul O. Farr, MD	X	X	X
Domenic R. Federico, MD	X	X	X
Mark W. Hinshaw, MD	-	-	-
Robert H. Hydrick, MD	-	X	-
James R. Irwin, MD	X	X	X
John M. MacKeigan, MD	X	-	X
Ann M. Minnema, MD	X	X	-
Ralph W. Ortwig, MD	X	-	-
John P. Papp, MD	X	X	X
Brian V. Phillips, MD	X	-	X
Sarla Puri, MD	X	X	X
John C. Rienstra, MD	-	-	-
Jack L. Romence, MD	-	-	-
Anthony Senagore, MD	X	X	X
Peter D. VanVliet, MD	-	-	-
James K. Watkins, MD	X	X	X
LAPEER:			
William G. Tucker, MD	X	X	X
LENAWEE:			
Inad Haddad, MD	X	X	-
Thomas J. McKeon, MD	-	-	-
LIVINGSTON:			
Thomas F. Higby, MD	-	X	X
LUCE:			
Steven A. Myers, MD	-	-	-
MACOMB:			
James B. Anderson, MD	X	X	X
Ben R. Fajardo, MD	-	-	-
Paul R. Gradolph, MD	-	-	-
Joseph M. Kriegel, MD	-	-	X
Byung S. Lee, MD	-	-	-
Samir M. Ragheb, MD	X	X	X
Richard A. Stone, MD	-	-	-
MANISTEE:			
Vickers C. Hansen, MD	-	-	-
Charles Poposki, MD	-	X	-
MARQUETTE-ALGER:			
Busharat Ahmad, MD	X	X	X
Randall M. Johnson, MD	-	-	-
Satish Shah, MD	X	X	X
MASON:			
Margaret E. Gustafson, MD	X	X	X
MECOSTA-OSCEOLA-LAKE:			
Michael R. Mekaru, MD	X	X	X
MENOMINEE:			
Herman R. Brukardt, MD	-	-	-
MIDLAND:			
Roy M. Goethe, MD	-	-	-
Thomas E. Lipps, MD	X	X	X
Gary S. Smith, MD	X	-	-
MONROE:			
David J. LIeberman, MD	X	X	X
Anthony E. Melonakos, MD	-	-	-
MUSKEGON:			
Stephen E. Fisher, MD	X	X	-
Michael A. Johnson, MD	X	X	X
Dick L. Kamps, MD	-	-	-
Rodney L. Mirich, MD	-	-	-
Robert C. Packer, MD	X	X	-
NEWAYGO:			
Michael J. Post, MD	X	X	-
NORTH CENTRAL:			
Warren E. Bontrager, MD	X	X	X
NORTHERN MICHIGAN:			
Reed K. Freidinger, MD	X	X	X
J. Douglas Gay, MD	-	-	-
Joseph W. Hance, MD	-	-	-
Dennis M. Joy, MD	X	X	X
Richard H. Wakulat, MD	X	X	X
OAKLAND:			
Jaime V. Aragones, MD	-	-	-
Joseph A. Arena, Jr., MD	-	X	X
Edward E. Barton, MD	X	X	X
Steven S. Bolton, MD	X	X	X
Arnold L. Brown, MD	-	-	-
Neldagae S. Chisa, MD	-	-	-
Hari G. Chopra, MD	X	X	-
Harry L. Doerr, MD	-	-	X
Nitin C. Doshi, MD	-	-	-

Edward E. Elder, Jr., MD	X	X	X
William S. Floyd, MD	-	X	X
George R. Gerber, MD	X	X	X
Kenneth W. Gitlin, MD	X	-	X
Harvey W. Halberstadt, MD	-	-	X
Quentin P. Hamilton, MD	X	X	X
Shamsul M. Haque, MD	X	-	X
Kamalesh Lahiri, MD	-	-	-
Bruce T. Lessien, MD	X	-	-
Robert S. Levine, MD	-	-	-
Thomas K. Mathew, MD	-	-	-
Alan M. Mindlin, MD	X	X	X
Mofid Mitri, MD	X	X	-
Peter T. Muller, MD	X	-	-
Steven E. Newman, MD	X	X	X
Renato G. Ramos, MD	X	X	X
James A. Read, MD	X	-	X
Joseph L. Shirle, Jr., MD	-	-	-
Armen Shekerjian, MD	X	X	X
Marvin L. Starman, MD	-	-	-
Sherry L. Viola, MD	X	-	-
OCEANA:			
V. Dale Barker, MD	-	-	-
ONTONAGON:			
James D. Bowen, MD	-	-	-
OTTAWA:			
William D. Doebler, MD	X	X	X
Arnold R. Dood, MD	X	X	X
M. Gary Robertson, MD	X	X	X
SAGINAW:			
Edgar P. Balcueva, MD	X	X	X
Leroy C. Barry, MD	X	X	X
Thomas A. Egleston, MD	-	X	X
Richard C. Hausler, MD	X	X	X
Richard P. Heuschele, MD	-	-	-
Ronald L. Jenson, MD	X	X	X
Robert Margulies, MD	X	X	X
Charles E. Mueller, MD	-	-	-
Jacob C. Ninan, MD	-	-	-
Caroline G. Scott, MD	-	X	-
ST. CLAIR:			
Timothy B. Aiken, MD	X	X	X
Syed Akram Ali, MD	X	-	-
Ronaldo S. Balboa, MD	-	-	-
John C. Sullivan, MD	X	X	X
ST. JOSEPH:			
Lawrence R. Werschky, MD	-	-	-
SANILAC:			
Duane E. Smith, MD	X	X	X
SCHOOLCRAFT:			
Duane L. Waters, MD	X	X	-
SHIAWASSEE:			
Timothy D. Oliver, MD	X	X	X
TUSCOLA:			
Alfonso C. Ferreira, MD	X	X	X
VAN BUREN:			
Michael J. Parks, MD	X	X	X
WASHTENAW:			
Tama Abel, MD	-	-	X
Allan C. D. Brown, MD	X	X	X
Robert H. Burke, MD	-	-	-
Karl J. Edelmann, MD	X	X	X
C. Peter Fischer, MD	-	-	-
Carl M. Frye, MD	X	X	X
Virginia L. Johnson, MD	-	-	-
Manfred Marcus, MD	X	X	X
John E. McGillicuddy, MD	-	-	-
Rhoda M. Powsner, MD	-	X	-
Terry E. Ragland, MD	X	-	X
Diana M. Rothman, MD	-	-	X
Douglas B. Siders, MD	-	-	-
Michael W. Smith, MD	-	X	X
Scott W. Woods, MD	X	-	-
Carl Van Appledorn, MD	-	-	-
WAYNE:			
Elie D. Aboulafia, MD	X	X	-
Robert D. Allaben, MD	X	X	X
Hassan Amirikia, MD	X	-	X
Howard P. Appelman, MD	-	-	-
Firooz Banooni, MD	X	X	-
Edmund M. Barbour, MD	-	-	-
Joseph M. Beals, MD	X	-	X
Joseph J. Berke, MD	X	X	X
Bharat K. Bhatt, MD	-	-	-
Joseph G. Bielawski, MD	X	X	X
David H. Blinkhorn, MD	-	-	-
R. John Bradfield, MD	X	X	X
Filiberto Cavazos, MD	-	X	X
Albert J. Ceravolo, MD	-	-	-
Ned I. Chalat, MD	-	X	X
Arthur M. Clark, MD	X	X	-
Lewis Clayman, MD	-	-	-
Martin H. Daitch, MD	X	X	X
Jerry Drake, MD	-	-	-
Paul J. Dzul, MD	-	-	-
Chandra M. Edwin, MD	-	-	-
Mark D. Faber, MD	-	-	X
Riad N. Farah, MD	-	-	-
Angel Farina, MD	X	X	X
John F. Fennessey, MD	X	X	X
Daniel L. Fink, MD	-	-	-
Fred W. Fitzpatrick, MD	X	X	-
Vincent J. Gallant, MD	-	-	-
Thomas Ganos, MD	X	X	X
Alma R. George, MD	-	-	-
Robert A. Gerisch, MD	X	X	X
Magdy M. Hanna, MD	-	-	-
W. R. F. Harnett, MD	X	X	X
William A. Harrity, MD	X	-	X
George C. Hill, MD	X	X	-
Andrew J. Hopkins, MD	-	-	-
Samuel D. Indenbaum, MD	X	-	X
John R. Ingall, MD	X	X	-
James K. Johnson, MD	-	-	-
Dorothy M. Kahkonen, MD	X	-	X
Charles Kessler, MD	-	X	-
Mark D. Kolins, MD	X	X	X
Stanley H. Levy, MD	-	X	X
Robert P. Lilly, MD	X	-	X
Gerald H. Mandell, MD	X	X	X
Girish C. Mangalick, MD	-	-	-
Marion G. McCall, MD	-	-	-
Thomas A. McDonald, MD	-	X	X
Richard Menczer, MD	-	-	-
Norman D. Moss, MD	-	-	-
Kevin M. O'Brien, MD	-	-	-
Steven E. Olchowski, MD	X	X	X
Joseph R. Oldford, MD	X	X	X
Harold Perry, MD	-	-	-
Sol D. Pickard, MD	-	-	-
Joseph L. Posch, MD	-	-	-
Russel F. Proud, MD	X	X	X
Clara Raven, MD	X	X	X
Foster K. Redding, MD	X	X	X
Morris V. Reiff, MD	-	-	-
Rojan Samudrala, MD	-	-	-
Vinod B. Sanghi, MD	X	-	-
Ivan C. Schatten, MD	X	X	X
Fred R. Severyn, MD	-	X	X
Jack Shapiro, MD	X	X	-
Yvan J. Silva, MD	-	-	-
Deborah W. Sims, MD	X	X	-
Orlando S. Sison, MD	X	X	-
Robert A. Songe, MD	-	-	-
Saul C. Stein, MD	-	-	-
Dorai K. Sukamaran, MD	-	-	-
Romeo H. Tabbilos, MD	X	X	-
Emanuel Tanay, MD	-	-	-
William C. Thompson, III, MD	-	-	-
Arthur A. Ulmer, MD	-	-	-
Jay Victor, MD	X	X	-
Joseph J. Weiss, MD	X	-	-
Fred W. Whitehouse, MD	-	-	-
William A. Willoughby, MD	-	-	-
Bernard J. Woodley, MD	X	X	X
David S. Yates, MD	-	-	-
Louis R. Zako, MD	-	X	X
WEXFORD-MISSAUKEE:			
Dennis E. Van Alst, MD	X	X	X
IMMEDIATE PAST PRESIDENT:			
Robert E. Paxton, MD	X	X	X
MEDICAL SCHOOL DEANS:			
University of Michigan:			
Not Represented			
Wayne State University:			
Robert J. Sokol, MD	-	-	-
Michigan State University:			
Not Represented			
HOSPITAL MEDICAL STAFF SECTION			
John A. Rupke, MD	X	X	X
MEDICAL STUDENT SECTION			
University of Michigan:			
Bret R. Gerber	-	X	X
Michigan State University:			
Rebecca S. Brienza	X	-	X
Wayne State University:			
Michael A. Stack	-	X	X
RESIDENT PHYSICIAN SECTION			
Douglas L. Colberg, MD	X	X	X
SECTION FOR INTERNATIONAL MEDICAL GRADUATES			
Allan C. D. Brown, MD	X	X	-
Ada E. Van Vloten, MD	-	-	X
SPECIALTY SOCIETY ORGANIZATIONS			
MI ALLERGY SOCIETY:			
Clyde R. Flory, MD	X	X	X
MI SOCIETY OF ANESTHESIOLOGISTS:			
David M. Krhovsky, MD	X	X	X
MI CHAPTER - AMERICAN COLLEGE OF CHEST PHYSICIANS:			
Not Represented			
MI SOCIETY OF COLON AND RECTAL SURGERY:			
Martin A. Luchtefeld, MD	-	X	X
MI DERMATOLOGICAL SOCIETY:			
Thomas D. Harris, MD	X	X	X
MI CHAPTER - AMERICAN COLLECT OF EMERGENCY PHYSICIANS:			
Charles C. Johnston, MD	-	-	-
MI ACADEMY OF FAMILY PHYSICIANS:			
Robert J. Toteff, MD	X	X	X
MI SOCIETY - GASTROINTESTIONAL ENDOSCOPY:			
Not Represented			
MI SOCIETY OF GENERAL SURGEONS:			
Donald C. Camp, MD	-	X	-

MI HEALTH OFFICERS ASSOCIATION:			
Edwin R. Larkin, MD	X	-	-
MI SOCIETY OF INFECTIOUS DISEASE:			
David B. Martin, MD	X	-	-
MI SOCIETY OF INTERNAL MEDICINE:			
John R. Maurer, MD	X	X	X
MI ASSOCIATION OF NEUROLOGICAL SURGEONS:			
Hugo Lopez-Negrete, MD	-	-	-
MI NEUROLOGICAL ASSOCIATION:			
Not Represented			
MI COLLEGE OF NUCLEAR PHYSICIANS:			
Not Represented			
MI SECTION - AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY:			
Domenic R. Federico, MD	X	X	X
MI OCCUPATIONAL MEDICAL ASSOCIATION:			
Not Represented			
MI OPHTHALMOLOGICAL SOCIETY:			
Paul P. Fecko, MD	-	-	-
MI ORTHOPAEDIC SOCIETY:			
Not Represented			
MI OTO-LARYNGOLOGICAL SOCIETY:			
James McKenna, MD	X	X	X
MI SOCIETY OF PATHOLOGISTS:			
Edwin M. Knights, Jr., MD	X	X	X
MI CHAPTER - AMERICAN ACADEMY OF PEDIATRICS:			
Irving M. Miller, MD	-	-	-
MI SECTION ON CLINICAL PHARMACOLOGY AND THERAPEUTICS:			
Not Represented			
MI CHAPTER - AMERICAN COLLEGE OF PHYSICIANS:			
John A. Papp, MD	-	-	-
MI ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION:			
Not Represented			
MI ACADEMY OF PLASTIC SURGEONS:			
Michael J. Schenden, MD	X	-	-
John H. Beernick, MD	-	X	X
MI PSYCHIATRIC SOCIETY:			
Max L. Gardner, MD	X	X	X
MI PSYCHOANALYTIC SOCIETY:			
Not Represented			
MI RADIOLOGICAL SOCIETY:			
Phillip E. Perkins, MD	X	X	X
MI CHAPTER - AMERICAN COLLEGE OF SURGEONS:			
Robert D. Allaben, MD	X	X	X
MI SOCIETY OF THERAPEUTIC RADIOLOGISTS:			
James R. Dolan, MD	X	-	-
MI SOCIETY OF THORACIC AND CARDIOVASCULAR SURGEONS:			
Allen Silbergleit, MD	X	-	X
MI THORACIC SOCIETY:			
Robert E. Klimek, MD	-	-	-
MI UROLOGY SOCIETY:			
Farid Jano, MD	-	X	X

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MEETINGS

MSMS Meetings

August

6, MSMS/MPMLC Current Issues in Risk Management, Marquette Medical Society, Marquette, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

8, MSMS/MPMLC Current Issues in Risk Management, Bay Valley, Bay City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

12-16, MSMS Practice Management Seminar "Medical Office Management Institute," Grand Traverse Resort, Traverse City, MI. Includes: "Successful Personnel Management Techniques," "Improving Your Managerial Effectiveness," "Patient Flow Management," Financial Management," and "Coding and Reimbursement." Contact: MSMS Office of Physician Education, (517) 337-1351.

13, MSMS/MPMLC Current Issues in Risk Management, Troy Hilton, Troy, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

19, MSMS/MPMLC Current Issues in Risk Management, Waterfront Inn, Traverse City, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

21, MSMS/MPMLC Current Issues in Risk Management, Grand Rapids Regional Center, Grand Rapids, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

27, MSMS/MPMLC Current Issues in Risk Management, Weber's Inn, Ann Arbor, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

29, MSMS/MPMLC Current Issues in Risk Management, Wayne County Medical Society, Detroit, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

September

10, MSMS/MPMLC Current Issues in Risk Management (evening program). Novi Hilton, Novi, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

11, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

11, MSMS Practice Management Seminar "Improving Your Practice Productivity And Performance In The 1990's." Hyatt Regency, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

12, MSMS/MPMLC Current Issues in Risk Management (evening program). Sheraton, Lansing, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

12, MSMS Practice Management Seminar "Improving Your Practice Productivity And Performance In The 1990's." University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

13-14, MSMS Practice Management Seminar "Starting Yourself In Medical Practice." Amway Grand, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

14-15, MSMS Practice Management Seminar "Improving Your Practice Productivity and Performance In The 1990's." Grand Hotel, Mackinac Island. Contact: MSMS Office of Physician Education, (517) 337-1351.

18, MSMS/MPMLC Current Issues in Risk Management (evening program). Port Huron Hospital, Port Huron, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

21, MSMS Practice Management Seminar "Balancing The Dimensions Of Your Life," a seminar for all physicians, residents, medical students and auxilians, sponsored by the MSMS Committee on Concerns of Women Physicians. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24,25,26, MSMS Practice Management Seminar "Advanced Coding and Reimbursement." September 24 at Holiday Inn, Marquette, MI; September 25 at Grand Traverse Resort, Traverse City, MI; and September 26 at Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

25,26, MSMS Practice Management Seminar "Medical Office Management for the Physician's Spouse." September 25 at Sheraton

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MEETINGS

Oaks, Novi, MI; September 26 at Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education or Dawn Reha, (517) 337-1351.

October

1,2,3, MSMS Practice Management Seminar "How to Improve Third-Party Reimbursement and Coding." October 1 at Dearborn Inn, Dearborn, MI; October 2 at Bay Valley Inn, Bay City, MI; October 3 at the University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

8,9,10, MSMS Practice Management Seminar "ICD-9CM Diagnosis Coding - How To Do It Right." October 8 at Grand Traverse Resort, Traverse City, MI; October 9 at Amway Grand Plaza, Grand Rapids, MI; October 10 at Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

16, MSMS Practice Management Seminar "Retirement Planning." University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

22,23,24, MSMS Practice Management Seminar "1991 BCBS Medicare Update Series." October 22 at University Club, East Lansing, MI; October 23 at Dearborn Inn, Dearborn, MI; October 24 at Bay Valley Inn, Bay City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24, MSMS Practice Management Seminar "Kerr, Russell, and Weber - Health Law Update (1/2 day)." Ann Arbor Regent, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

29, AMA-MSMS Medical Office Staff Training Series. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

November

12-14, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, MI. Over 50 courses offered. Contact the MSMS Office of Physician Education, (517) 337-1351 for a complete meeting program.

Michigan Specialty Society Meetings

October

26, The Universal Resistance to Child Analysis, Chicago, IL. Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

November

16, Seventeenth Annual Symposium, "Improving Clinical Skills: Lessons from Longer Psychoanalytic Treatments." Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

August

10-16, Tenth Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance In Medicine, San Francisco, CA. Contact: (415) 841-1899.

17-20, Academy of Psychosomatic Medicine 38th Annual Meeting, Atlanta, GA. Contact: Executive Director, (312) 784-2025.

October

10-13, American Society of Internal Medicine 35th Annual Meeting. Contact: Lisa Derby, (202) 289-1700 ext. 615.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

August

8-11, Cardiology Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 12 hours Category I Credit.

10-11, Endocrinology and Diabetes Update. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine and Michigan Diabetes Research and Training Center. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 8 hours Category I Credit.

11-14, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 11 hours Category I Credit.

15-17, Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 746-2288. **Approved for:** 13 hours Category I Credit.

September

14, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 6 hours Category I Credit.

30-10/1, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. **Contact:** Julie Jones, Office of Continuing Medical Education, G1100 Towsley Center, P. O. Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 14 hours Category I Credit.

October

25-26, Advanced Cardiac Life Support Instructors Course. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsors:** Michigan Chapter of the American College of Emergency Physicians and American Heart Association of Michigan. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 16 hours Category I Credit.

November

14-15, Advanced Pediatric Life Support Course. Location: Children's Hospital, Detroit, Michigan. **Sponsors:** American Academy of Pediatrics and Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

18-19, 15th Annual Michigan Fall Radiology Conference. Location: The Townsend Hotel, Birmingham, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 14 hours Category I Credit.

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BATTLE CREEK: Two FP opportunities in this outstanding community in south central Michigan. One is to join a well established FP in new office building. $90,000 guarantee plus benefits first year, partnership after one year. OB a must. Also need two FP's for practice in new health park, guarantee $80,000-$90,000, OB not mandatory. For additional information contact: Greg Peterson, The Peterson Group, 8700 Monrovia, Suite 302, Shawnee Mission, KS 66215 or call (800) 669-4804.

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FAMILY PHYSICIAN: Wanted to join non-profit community health center program. BC/BE. Modern facility in rural community in central **Upper Peninsula** of Michigan. OB and hospital required. Competitive salary, excellent benefits. Possible loan repayment. Immediate opening. Send CV to: Donna Jaksic, Executive Director, Upper Peninsula Association of Rural Health Services, 220 W. Washington, Suite 430, Marquette, MI 49855; (906) 228-3613.

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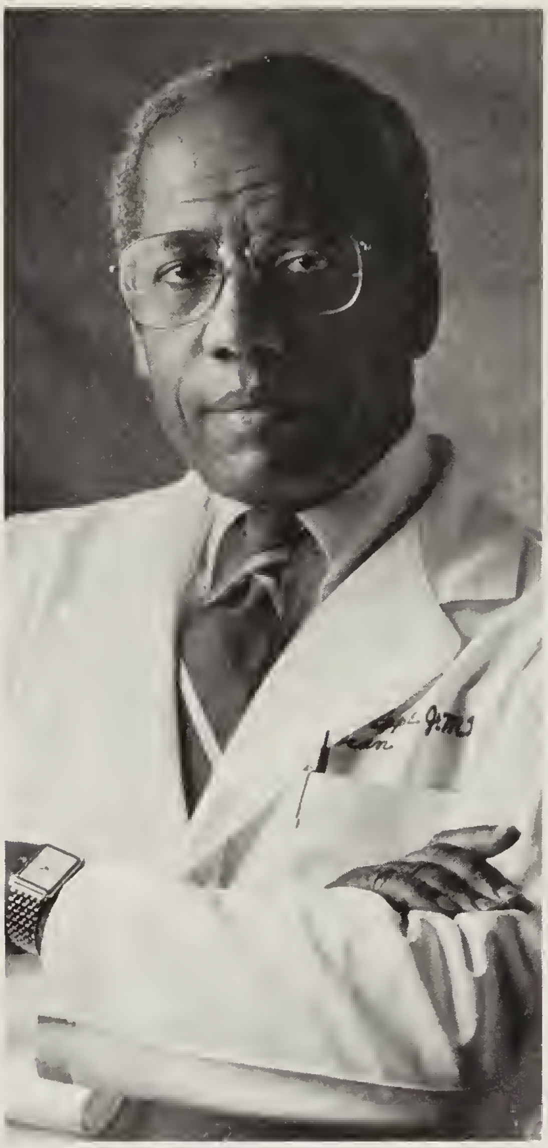
A message from The American Medical Association for the Health Access America Proposal



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"I think that doctors who don't belong don't realize it, but they benefit every day from actions that the AMA is taking."

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Lab of Clinical Medicine	8
McDonald & Co	6
Meade Leasing	54
Medfirst	70
Medical Automation	22
Medical Billing Service	2
Medicalis	61
MPMLC	IFC
Nationwide Collections	66
Palisades Pharm	24
PC Medical	61
Physician Service Group	1
PICOM	36
Prescott, Ball & Turben	32
Rice Clinic	65
Sohn Laundry	68
St. Luke's	5,44
US Air Force	26
US Army	58
Women's Health Center	62

PRESIDENT'S PAGE

Public health: It's everybody's business

By Robert D. Burton, MD

In June, we got together with Vernice Davis Anthony and Ron Davis, MD, the new director and medical director of the Michigan Department of Public Health, to swap ideas and priorities concerning public health.

Both groups had quite a laundry list of issues to discuss: Professional liability and its impact on health care delivery; development of a state legal expense fund; practice parameter development; consolidating administrative functions of the MDPH; and certificate of need reform.

But it was the discussion of actual public health issues that were most interesting. We talked about adolescent health. We discussed anti-smoking initiatives. We looked at our high infant mortality rate and environmental health problems.

Many of these public health hydras will not be easily overcome, if, for that matter, overcome at all. But what has been stewing in my mind since that meeting were comments by both directors that we need to get people to take greater responsibility for their own health.

How true. Public health really is not just the business of the public health department. **Public health is everybody's business!**

Of course, overcoming the public health effects of our polluted environment is not an individually achievable goal. Our rapid move into the industrial age has carried some heavy public health baggage; toxic chemical pollution, air pollution, acid rain. Nor is lowering our high infant mortality rate going to be a simple matter.

A role for everyone

But there are things an individual can do, things that every individual can do. People have to make the right choices about their lifestyles as they affect their health. They have to have the right information to make the right choices. And they have to have the reinforcement from us, from physicians, to help them do the right thing.

Michigan has the dubious distinction of leading the nation in excess deaths from nine chronic diseases, according to a study published in the November 28, 1990, issue of the *Journal of the American Medical Association.*

The authors concluded that many deaths from these nine diseases — stroke, coronary heart disease, diabetes, chronic obstructive pulmonary disease, lung cancer, female breast cancer, cervical cancer, colorectal cancer, and chronic liver disease/cirrhosis — are, in large part, preventable.

"Of the nine risk factors examined singly for their contribution to deaths from the nine diseases, the largest proportion — 33 percent — was attributable to cigarette smoking," according to the study. "Examined one at a time, five other risk factors also contributed large proportions of death from these causes: obesity (24 percent), a sedentary lifestyle (23 percent), high cholesterol level (23 percent), hypertension (21 percent), and diabetes (8 percent). Other risk factors — heavy alcohol consumption and nonutilization of mammography and Papanicolaou smears — contributed a maximum of less than one percent each (although they contributed substantial proportions of deaths from specific diseases: chronic liver disease, breast cancer, and cervical cancer, respectively."

Imagine, then, if we physicians took the lead and were able to educate and convince our patients, and all of society, that they could live longer, healthier, less costly lives if only they would alter the harmful lifestyles in which so many indulge.

Unfortunately, our message does not have the riveting appeal of crack cocaine, or the taste of fat upon our tongues. It does not have the hidden sexual appeal of beer commercials or the self-gratification of cigarette ads.

So what if you may add years to your life? So what if you will live happier and healthier and cheaper?

In a country so brainwashed by slick, multi-million dollar advertising campaigns about the joys of excess, how will we ever get a message across about common sense and moderation in personal lifestyles?

The answer, really, is simple. The Michigan Department of Public Health is committed to doing its part. And we will have to do our part.

One person at a time

We will have to do it one person — one patient — at a time.

We will have to take an extra minute or two, maybe five, maybe more, to educate that drinker, that smoker, that non-exerciser, that drug user, that refrigerator operator, about the effects of their behavior on their own health, and how their behavior affects others around them and all of society.

We've got to try to make public health **everyone's** business. What would we be if we didn't try? It won't be easy. But when in medical school did anyone ever tell you it was going to be easy?

Doctor Burton is MSMS president.

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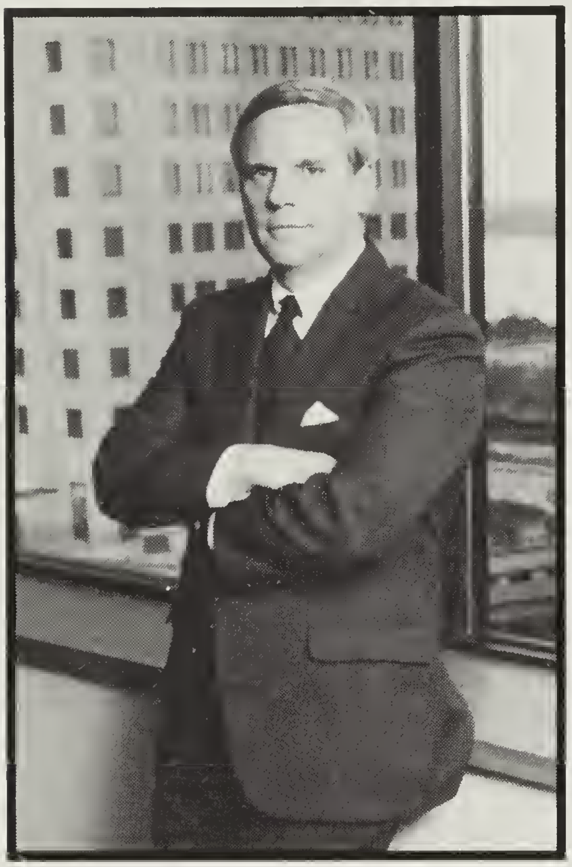

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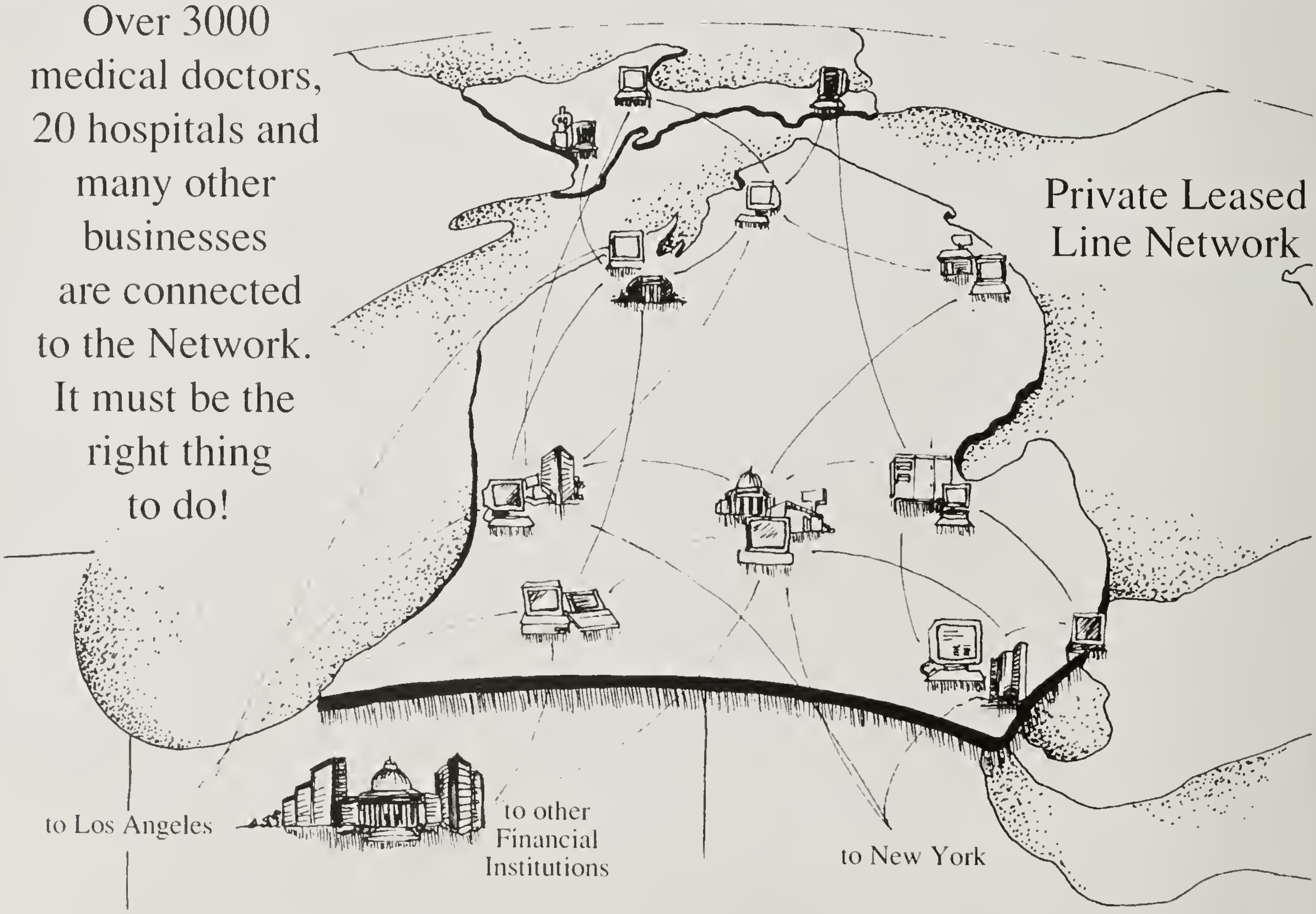

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MICHIGAN MEDICINE

SEPTEMBER 1991 VOLUME NO 9

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

The American Medical Association has declared September "Women in Medicine Month" – a time to celebrate the great strides made by women in what, until recent years, has been a predominantly male profession. It is also a time to focus on bringing more women physicians into the mainstream of organized medicine. This month's cover story presents a wide array of articles on women in medicine. Included are profiles of four outstanding women physicians who have been inducted into the Michigan Women's Hall of Fame. In addition, you will find a report from the MSMS Committee on Concerns of Women Physicians, and biographical sketches of some of Michigan's leading women physicians. These articles and more begin on page 14.

37

Insurance Commission Report on the Blues Reversed

MSMS legal counsel explains the recent decision of a special hearing officer to reverse a report approving the Blues' Provider Class Plan for 1987-88.

By Thomas R. Williams

39

Practice Management

This first in a new series of articles on practice management explains why interest charges aren't the best way to collect on overdue bills.

By Randall W. Braaksma

43 Medical Inquirer

This is the sixth in a series of factsheets prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians.

45

Malpractice Arbitration

An explanation of why it is the key to liability reform.

By Randall W. Braaksma

49

MSMS Annual Scientific Meeting

The MSMS Annual Scientific Meeting is just around the corner! Featured are a capsule schedule of events and registration form.

DEPARTMENTS

7 MSMS ON THE MOVE

9 NEWSFRONTS

11 PHYSICIANS IN THE NEWS

56 MEETINGS

58 CATEGORY I COURSES

61 CLASSIFIEDS

63 ADVERTISING INDEX

64 PRESIDENT'S PAGE

In next month's issue:

MSMS Annual Scientific Meeting Official Program

Cover illustration: *By Robert L. Brent*

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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MSMS ON THE MOVE

A monthly update of key MSMS activities

Physician media contacts/testimony sought on liability reform

MSMS is urging members of the Physicians Communication Network (PCN) and others to reinforce the liability message by contacting the media through letters to the editors of their local newspapers. In a recent mailing to PCN members, MSMS Board members, the MSMS Committee on Communications and Professional Relations, Hospital Medical Staff Section delegates, component society executives, and specialty society presidents, Board Chairman Jack L. Barry, MD, said, "We are reaching a crucial point in our efforts to build momentum on liability reform and your help is essential to our success. It is urgent that we keep up the momentum by keeping the public informed through the media and other mechanisms." A sample letter-to-the-editor was included, along with materials outlining the crisis.

MSMS continues to seek physician testimony for public hearings on Senate Bills 248-249, the Michigan Medical Liability Determination Act, also called the Michigan Alternative. The hearings, which began in June, are being conducted statewide by the Medical Liability Subcommittee of the Senate Judiciary Committee. Physicians who can't testify may submit written comments to Tom Wolff at MSMS for submission to the subcommittee. Two hearings are scheduled for September – Sept. 5 at 2:00 p.m. at the BCBSM offices in Detroit; and Sept. 17 at 1:00 p.m. in room 402 of the State Capitol in Lansing. For further information, contact Tom Wolff at MSMS.

Statewide seminars sharpen physician practice management skills

The MSMS Office of Physician Education has several excellent workshops and seminars lined up for physicians in September. "Improving Your Practice Productivity and Performance in the 1990s," designed to help physicians overcome the problems of practicing medicine, will be offered Sept. 11 in Dearborn; Sept. 12 in East Lansing; and Sept. 14-15 on Mackinac Island. "Starting Yourself in Medical Practice" in Grand Rapids on Sept. 13-14 will provide step-by-step procedures on how to start a successful medical practice. A seminar conducted last spring and being repeated because of its popularity is "Making BCBSM Work For You" Sept. 19 in Dearborn and Oct. 9 in Grand Rapids. Physician payment reform, the new participation agreement, billing issues and the appeals process are among the topics which will be covered. For details on these and other seminars, call the MSMS Office of Physician Education at (517) 337-1351.

MSMS lobbies Congress for changes to HCFA's proposed rules

Physicians have focused their attention on lobbying Congress for changes in HCFA's proposed rules on reimbursement. Many physicians around the country responded to HCFA prior to an Aug. 5 deadline, expressing their opposition to the proposed rules. Since that deadline has passed, physicians are now putting pressure on their congressmen and senators to force HCFA to change the proposed rules, which it plans to finalize in the early fall. The rules would be part of the new Medicare payment system based on a resource-based relative value scale (RBRVS) that will take effect Jan. 1, 1992. They call for a 16 percent reduction in the conversion factor that would change relative value units for physician work under the new system into Medicare dollars. MSMS, along with 18 other state medical societies, sent a physician delegation led by President Robert D. Burton, MD, and Board Chairman Jack L. Barry, MD, to Washington in late July to lobby Michigan congressmen and senators for changes in the proposed rules. MSMS plans to continue lobbying Congress for changes until HCFA finalizes the proposed rules. For assistance in contacting your congressmen and senators on HCFA's proposed rules, contact Kevin A. Kelly at MSMS.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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MEDICAL NEWSFRONTS

AMA campaigns against Medicare cuts

The physicians of America are outraged by the Health Care Financing Administration's proposed cuts in the new Medicare payment system that goes into effect next year. That's the message AMA Executive Vice President James S. Todd, MD, gave June 10 in a statement to the Physician Payment Review Commission.

HCFA has announced that it will reduce the initial conversion factor by 16 percent below originally projected levels. The conversion factor will be used in conjunction with a resource-based relative value scale to determine physician payments.

Payments to physicians whose services consist mostly of visits, such as internists and family physicians, may increase next year, but at a substantially lower level than had been expected. Payments to physicians whose services consist mostly of procedures, such as surgeons, will be reduced even further below anticipated levels by 1996.

"Physicians can only conclude that the federal government has broken faith with the medical profession and its patients," Doctor Todd said. "The AMA, working with all of organized medicine, is embarking on a major effort to reverse these cuts," he said. The campaign will include public comments to HCFA about its Notice of Proposed Rule Making, unprecedented grass-roots lobbying and legislative initiatives.

State of medical education reviewed in new book by former MSU medical school dean

American medical colleges need to improve on many different fronts, including how students are recruited and educated, how specialty training is conducted, and in the way continuing medical education is offered, says Andrew D. Hunt, MD, founding dean of Michigan State University's College of Human Medicine.

These problems, along with some solutions, are discussed in a new book by Doctor Hunt, titled "Medical Education, Accreditation and the Nation's Health: Reflections of an Atypical Dean."

Hunt served as the College of Human Medicine's dean from its founding in 1964 until he stepped down in 1977. He retired from the university in 1984. He now is part-time associate dean of the Mercer University (Ga.) School of Medicine.

In "Reflections," Doctor Hunt combines historical narrative with autobiographical observations to illustrate his argument for reform of the American medical education system. He includes critical accounts of significant events in American medical education, important educational innovations, the history of federal support of medical research, and an outline of the medical school accreditation process.

The book concludes with a set of recommendations designed to provide medical students with a more realistic understanding of society's needs and some measure of "justice" within the health care system.

New breast, cervical cancer program targets low-income women

"Michigan women aged 40 and older will soon be able to obtain life-saving breast and cervical cancer screening tests through their local health departments," said Vernice Davis Anthony, director of the Michigan Department of Public Health. With this statement, Anthony recently announced receipt of three million dollars per year of new funding for at least five years from the US Centers for Disease Control (CDC) to establish a breast and cervical cancer screening program for low-income Michigan women. Future increases in funding are likely. The funds will be used to pay for screening services, some diagnostic services, statewide public and professional education, quality assurance, surveillance, and evaluation.

"Eleven local health departments will receive grants in 1991 to provide or arrange for screening and follow-up services to women in their jurisdictions," Anthony said," and more than half of Michigan's 50 local health departments are expected to have these services available in 1992."

Within three years, these services should be available in each of Michigan's 83 counties, according to Anthony.

Nearly 5,600 women in Michigan were diagnosed with breast or cervical cancer in 1989.

For additional information about the new breast and cervical cancer program, please call Carol Callaghan, Cancer and Tobacco Unit, (517) 335-9161.

AMA offers "fresh advice" for physicians

Financial planning ideas are available to physicians on 12 audio cassette tapes developed by the AMA called – *Fresh Advice*. Each tape offers advice on practice and personal financial management. Each topic is presented in a clear and concise discussion, with the main ideas summarized in a printed outline. Discussions range in length from 12 minutes to 38 minutes. 1991 topics include:

- Contracting With the New Associate Physician: Nine Important Tips
- How to Fire the Difficult Staff Employee
- Physician Buy-Sell Agreements: Avoid the Seven Most Common Mistakes
- Techniques to Protect Your Personal Assets from Malpractice Claims

Continued on next page

- A Technique to Admit the New Partner — Fairly and Painlessly
- An Idea for Eliminating Retirement Plan Headaches in Your Practice
- Keeping Life Insurance Priorities Straight for Yourself and Your Partners
- Providing Better Staff Fringe Benefits at Less Cost
- Employee Handbooks: How to Avoid the Six Biggest Mistakes Made by Physicians
- A Cure for Your Practice's Sick Leave Policy
- How to Increase the Real Value of Your Life Insurance
- Estate Planning: 16 Points of Concern

The 1991 *Fresh Advice* library is packaged in a book-size hard binder that facilitates sharing with colleagues, and may be purchased at $159/AMA members; $169/nonmembers.

To order *Fresh Advice*, call the AMA at (800) 621-8335 and request NL372491.

MDPH offers testing and vaccine to prevent perinatal hepatitis B transmission

The Michigan Department of Public Health (MDPH) recently received funding from the CDC to initiate a statewide perinatal hepatitis B screening and immunization program. The basic goals of the program are to identify pregnant women infected with the hepatitis B virus (HBV), and to immunize their infants with the three-dose vaccine series and with hepatitis B immune globulin. MDPH can provide free hepatitis B surface antigen (HBsAg) screening for pregnant women as well as hepatitis B immune globulin (HBIG) and hepatitis B vaccine for HBV-exposed newborns. The Department is working closely with hospitals and local health departments to coordinate this program and assist with infant follow up for the second and third doses of vaccine.

Questions about the program can be directed to Nancy Fasano, project manager (517) 335-9423, or David Johnson, MD, medical epidemiologist (517) 335-8050 at the Michigan Department of Public Health.

U-M scientists working on artificial "hearing aid"

Researchers at The University of Michigan College of Engineering have developed a microchip that can record up to eight times more acoustic nerve signals in the brain than current probes.

Neuroscientists at the U-M say the new probe will help them understand how the brain functions to hear sounds. Someday — perhaps before the year 2000 — researchers affiliated with the U-M's 10-year-old biosensor probe project hope their work will produce not only a better understanding of hearing, but also an artificial "hearing aid" designed to be implanted in the human brain to restore some types of hearing loss.

The new recording probe, about the size of a speck of pepper, was developed by Jin Ji, U-M research fellow in electrical engineering and computer science. An advanced version of earlier probes developed by the research team at the U-M Center for Integrated Sensors and Circuits, Ji's probe allows scientists to monitor nerve signals from up to eight closely placed sites in the brain simultaneously, rather than the one - or two - site maximum possible with current probes. The probe was a first-place winner in an August 1990 national student contest for innovative design in microelectronic chips.

Lung/breast cancer outnumber others in state, MDPH reports

Cancer of the lung and bronchus was the most frequently diagnosed cancer among Michigan residents in 1989 with 5,216 cases, according to a new report released recently by the Michigan Department of Public Health. Breast cancer ranked a close second with 5,101 cases. Lung and bronchus cancer was also the leading cause of cancer death among Michigan residents in 1989, accounting for 27 percent of all cancer deaths in that year. Between 1970 and 1989, age-adjusted death rates due to cancer of this site increased 180 percent among white females and 237 percent among black females.

Breast cancer was the leading cancer diagnosed among women, accounting for 30 percent of all female cases. However, lung cancer was the leading cause of death among women.

Over one-half (53 percent) of all 33,774 cancer cases diagnosed in 1989 originated in one of four anatomical sites: the breast, lung and bronchus, prostate, or colon.

Cancer of the prostate was the third leading cancer diagnosed in 1989 among all Michigan residents. It was the leading site of cancer among males, accounting for one out of every four male cancer cases.

Volunteers needed for headache study

Michigan Head-Pain and Neurological Institute (MHNI) in Ann Arbor is seeking individuals with recurrent headache for two preventive medication studies. Joel R. Saper, MD, Director of MHNI and president of the American Association for the Study of Headache, is the principal investigator.

The first project involves the use of fluoxetine for the prevention of intermittent migraine and chronic daily headache. Fluoxetine, a reuptake blocker, has been found useful in clinical practice to reduce the frequency and intensity of chronic headache. This study, using a four-month, placebo-controlled format, allows the limited use of symptomatic medication on an "as-needed" basis.

Depakote, a GABA-mimetic, is a potential new addition to the armamentarium of anti-migraine drugs. Recent clinical trials suggest the efficacy of Depakote in various forms of headache. The purpose of this study is to evaluate its benefit in the prophylactic treatment of episodic migraine.

Subjects are currently being screened for entry into each of these preventive medication studies for recurrent headache. Specific evaluation, testing, and treatment are sponsored by research grants for individuals who meet entry criteria. For more information; contact MHNI at (313) 973-1155.

PHYSICIANS IN THE NEWS

Robert E. Paxton, MD

named "Family Physician of the Year"

Robert E. Paxton, MD, a Fremont family physician and a past president of MSMS, has been named 1991 "Family Physician of the Year" by the Michigan Academy of Family Physicians.

A graduate of the University of Illinois Medical School, Doctor Paxton has held several leadership positions in the Michigan State Medical Society. During his tenure at MSMS from 1979 to 1991, Doctor Paxton served as chairman of the MSMS Finance Committee, chairman of the MSMS Task Force on Professional Liability, chairman of the MSMS Board of Directors and then, in 1989-90, as MSMS president. In July 1991, Doctor Paxton was honored by MSMS for his many years of service to the medical society.

Board certified in family practice, Doctor Paxton has been in private practice in Fremont since 1955.

Eli M. Brown, MD

chairman, Department of Anesthesiology, Sinai Hospital, Detroit, is the winner of the William McQuiston, MD, Award. The award is presented yearly to the anesthesiologist with a national education who has made significant contributions to the practice of anesthesiology. Doctor Brown is the first doctor from Michigan to receive this honor sponsored by the Illinois Society of Anesthesiologists.

Annamaria D. Church, MD

a pediatrician, St. Joseph Hospital, Pontiac, has received the 1991 Child Advocate Award from the Oakland County Child Abuse and Neglect Council.

Roy J. Gerard, MD

East Lansing, recently received the Michigan Academy of Family Physicians' Family Practice Educator of the Year Award. Doctor Gerard recently retired as chairman of the Department of Family Practice, Michigan State University College of Human Medicine. He was in private practice in Saginaw for 16 years and was director of family practice residency program at Saginaw Cooperative Hospitals before coming to MSU. The Academy also presented Doctor Gerard its Lifetime Achievement Award, the second time the organization has given the award.

Stanislaw Golec, MD

a staff psychiatrist, Detroit Receiving Hospital and University Health Center, recently participated in a four-week volunteer project to help establish an emergency psychiatry system in Poland. His efforts were part of a United Nations project which encourages professionals who have emigrated from underdeveloped countries to return to their homelands and use their knowledge and skills to improve conditions in those countries.

The Michigan Allergy Society

recently elected new officers. They are: **James Fordyce, MD**, president; **Ling Shih, MD**, president-elect; **Dennis Ownby, MD**, secretary; and **Richard Townley, MD**, treasurer.

The Michigan Occupational Medical Association

recently elected new officers for 1991-92. They are: **Martin L. Charles, MD**, president; **John Bernick, MD**, president-elect; **Thomas Hal Morley, MD**, vice president; **John H. Triebwasser, MD**, secretary; and **Mark Upfal, MD**, treasurer. Elected directors are: **James J. Andonian, MD**, **Robert J. Brandt, MD**, and **Michael Goldstein, MD.**

Andrew Saxe, MD

is the new president-elect of the Detroit Surgical Association for 1991-92. He has been the organization's treasurer since 1989. Doctor Saxe, of Birmingham, has been chief of Endocrine Surgery, Department of Surgery, Sinai Hospital, Detroit, since 1985. Prior to that, he was senior surgeon, National Cancer Institute, Bethesda, Maryland.

MICHIGAN STATE MEDICAL SOCIETY

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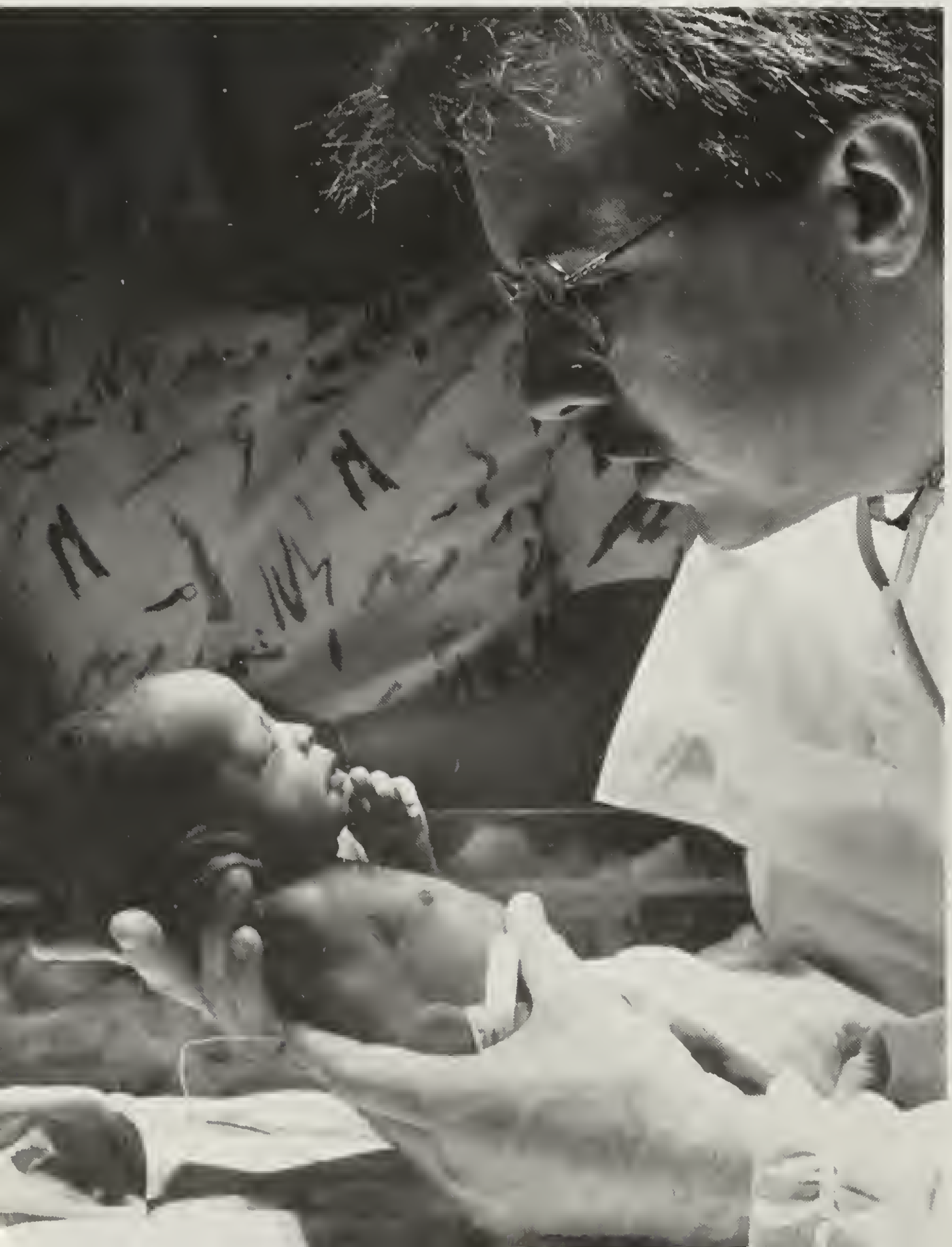

“As doctors, if we do the right thing at the right time we can make a difference.”

Dr. Kenneth A. Haller, Pediatrician, East St. Louis, Illinois, Member, American Medical Association

In one of the nation's poorest communities, Dr. Kenneth Haller is working not only to save children's lives, but to bring dignity to the lives of their parent

He is the type of physician who brings distinction our profession. He is the type of physician who uphol the highest ideals of medicine. He is also a member of the American Medical Association (AMA).

“I read the Principles of Medical Ethics of the AM and was impressed by it. I'm proud to be a member,” says Dr. Haller.

You are invited to join Dr. Haller and to join with him in his efforts to bring quality health care to those i need. Become a member of the American Medical Association today.

American Medical Association

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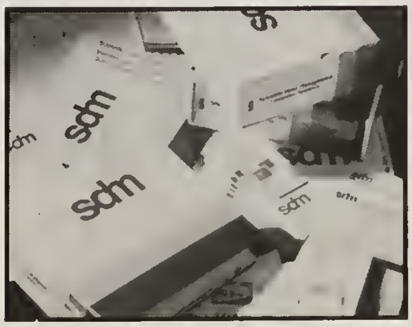

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COVER STORY

WOMEN IN MEDICINE

The American Medical Association has declared September "Women in Medicine Month" – a time to celebrate the great strides made by women in what, until recent years, has been a predominately male profession. It is also a time to focus on bringing more women physicians into the mainstream of organized medicine. This month's cover story presents a wide array of articles on women in medicine. Included are an indepth report on the history of women in medicine in the United States, plus profiles of four outstanding women physicians who have been inducted into the Michigan Women's Hall of Fame. Also included are stories by two women physicians, one about the challenges of becoming a physician, the other about balancing career and family. In addition, you will find a message from the MSMS Auxiliary to spouses of women physicians, a report from the MSMS Committee on Concerns of Women Physicians, and biographical sketches of some of Michigan's leading women physicians. These articles and more appear on the following pages.

A message from the AMA

Anyone who has taken a good look at a typical medical school class these days has to have noticed that the faces of medicine are changing.

More and more women are joining the profession's ranks and this trend is expected to continue.

Today, women comprise nearly 40 percent of all students entering medical schools, compared to about 10 percent 20 years ago. And in that time, the number of women physicians has nearly quadrupled.

By the year 2010, women will represent almost one-third of the physician population. So, clearly, the numbers of women in medicine are growing by leaps and bounds.

The AMA has long been supportive of women in medicine. Back in 1868, the Association urged its members to allow women to enter both the profession and the association. Five years later, while the US Supreme Court was still allowing states to prohibit women from practicing medicine, the AMA was listing women physicians in its membership directory.

Today, the AMA has a Women in Medicine Advisory Panel to encourage women physicians and women medical students to become more involved in the AMA.

Along with the Advisory Panel, an Office of Women in Medicine Services works to accomplish these goals.

The AMA activities include:

- *The Women in Medicine Data Bank* – a record of women physician leaders which is useful for recruiting speakers and candidates for leadership positions.
- An *Information Clearinghouse* – the central resource for information on and about women in medicine, including data on the numbers and characteristics of women physicians and women medical students.
- *Issue analyses* spearheaded by the AMA Advisory Panel and Women in Medicine Services on topics such as parenting in medicine, sexual harrassment and discrimination, and residency interviews.
- *Membership support* to help county, state and national medical specialty societies increase participation and leadership among women in medicine.

It is crucial that women become involved in professional activities at the grassroots level so that they can contribute their perspectives – as physicians and as women in medicine – to health care policy development and the medical profession. This should start through activities at the state and local levels and work its way up to the national level.

The time has come for women to become an integral part of the mainstream medical community. Together there is so much we can do to tap the fullest potential of all of our members and to give women every opportunity to join our leadership ranks. ■

MSMS *members interested in joining the* AMA *may contact Deborah Zannoth,* MSMS *Membership Department,* 517/337-1351.

Women in Medicine Fact Sheet

I. The Number of Women in Medicine has Grown Dramatically.

US Physicians	1970	1980	1989
Total	334,028	467,679	600,789
Male	308,627	413,395	502,343
Female	25,401	54,284	98,446

Projection: By the year 2010, 30 percent of physicians will be women.

II. Women in Medical School: In the fall of 1989, women comprised over 38 percent of students entering American medical schools, compared to only nine percent 20 years earlier.

III. Women in Residency Training: According to the 1989 *Journal of the American Medical Association* medical education issue, approximately 85,000 resident physicians were on duty as of September 1989. Women constituted almost 29 percent. More than one-third of women residents were training in internal medicine or pediatrics. Another 28 percent were in obstetrics/gynecology, family practice, or psychiatry.

IV. Women in Medical Practice: The total number of women physicians more than doubled between 1970 and 1980. By 1989, the number had increased nearly 288 percent to approximately 98,500 women physicians, or 16.4 percent of all physicians.

Characteristics:

A. *Specialty:* In 1967, only seven specialties had more than 1,000 women physicians. By 1989, 15 specialties had more than 1,000 women physicians. However, all seven of the specialties having the most women in 1967 remained the same in 1989. They are (in descending order): internal medicine, pediatrics, general practice, psychiatry, Ob/Gyn, anesthesiology, and pathology. In 1989, these specialties represented 67 percent of the total female physician population. Women are about three times as likely as men to be pediatricians and less than half as likely to be in general surgery or a surgical subspecialty.

B. *Activity:* In comparison to 1970, women physicians in 1989 were more likely to be in office-based practices (46 percent of all women) although they still represented just 12.9 percent of all office-based physicians.

In academic medicine, the percentage of women medical school graduates joining medical school faculties has been consistently higher than that of men. However, in 1989, although 20 percent of full-time faculty were women, only three of US medical schools deans were women and nine percent were professors.

C. *Age:* Female physicians are younger, on average, than male physicians. In 1989, almost 73 percent of female physicians were under age 45, with the largest number being between 30 and 39 years old.

D. *Work Hours:* Female physicians work about 10 percent fewer hours per year than male physicians and they spend about five to six fewer hours per week on practice activities. The average number of total weekly patient visits for female physicians is also lower than for male physicians.

E. *Income:* In 1988, female physicians earned 63 percent of the male mean annual net income amount, although the growth rate for females since 1981 was higher. Contributing factors in the lower incomes for women physicians are that women are overrepresented in the lower-paid specialties, are more often in salaried positions, work fewer hours, see fewer patients and are younger.

Source: The American Medical Association.

MSMS Committee addresses concerns of women physicians

By Martha L. Gray, MD

As more women enter the medical profession, the nature of organized medicine will need to change. The needs of all members – particularly women – will need to be recognized and met.

Initially, the development of separate programs and committees for women – such as the MSMS Committee on Concerns of Women Physicians – will serve to help women physicians take more active leadership roles in a profession which is facing many complex issues.

Although the number of women physicians is rapidly increasing, women are not joining organized medicine in the same proportions. The role of the MSMS Committee on Concerns of Women Physicians is to explore the reasons why this is happening, and offer suggestions and support systems that will facilitate the movement of more women physicians into organized medicine.

The Committee has carried out its goals by sponsoring annual workshops, providing women physicians as speakers for small groups and as mentors for female medical students and residents. It has circulated statistical information pertinent to women physicians, and has raised the awareness of many about the role women physicians already play in organized medicine. The Committee has also encouraged the appointment of many qualified women to committees and task forces of the AMA, MSMS, and county and specialty societies.

Input has been provided by the Committee on planning educational programs and meetings that are convenient for all physicians who prefer a reasonable balance in their personal and professional activities. The Committee has also made suggestions to offer day care and other family activities during medical conferences. MSMS will be testing some of these ideas on September 21, when the Committee presents a seminar on "Balancing the Dimensions of Your Life," offering child care opportunities to the physicians, residents, students and auxilians who have been invited to attend.

The Committee continues to sponsor programs at the MSMS Annual Scientific Meeting. The Committee has also developed a network for women physicians to share specific concerns with their colleagues, female medical students, residents and others in the medical profession. A Women Physician's Directory was published in 1990 to support these networking efforts.

Until the need to have a committee for women physicians subsides, the MSMS Committee on Concerns of Women Physicians will continue its efforts to encourage and support women physician participation in every facet of medicine.

For more information on the Committee, contact Lori Randall at MSMS, (517) 337-1351.

Doctor Gray is chairman of the MSMS Committee on Concerns of Women Physicians.

MSMS Committee on Concerns of Women Physicians

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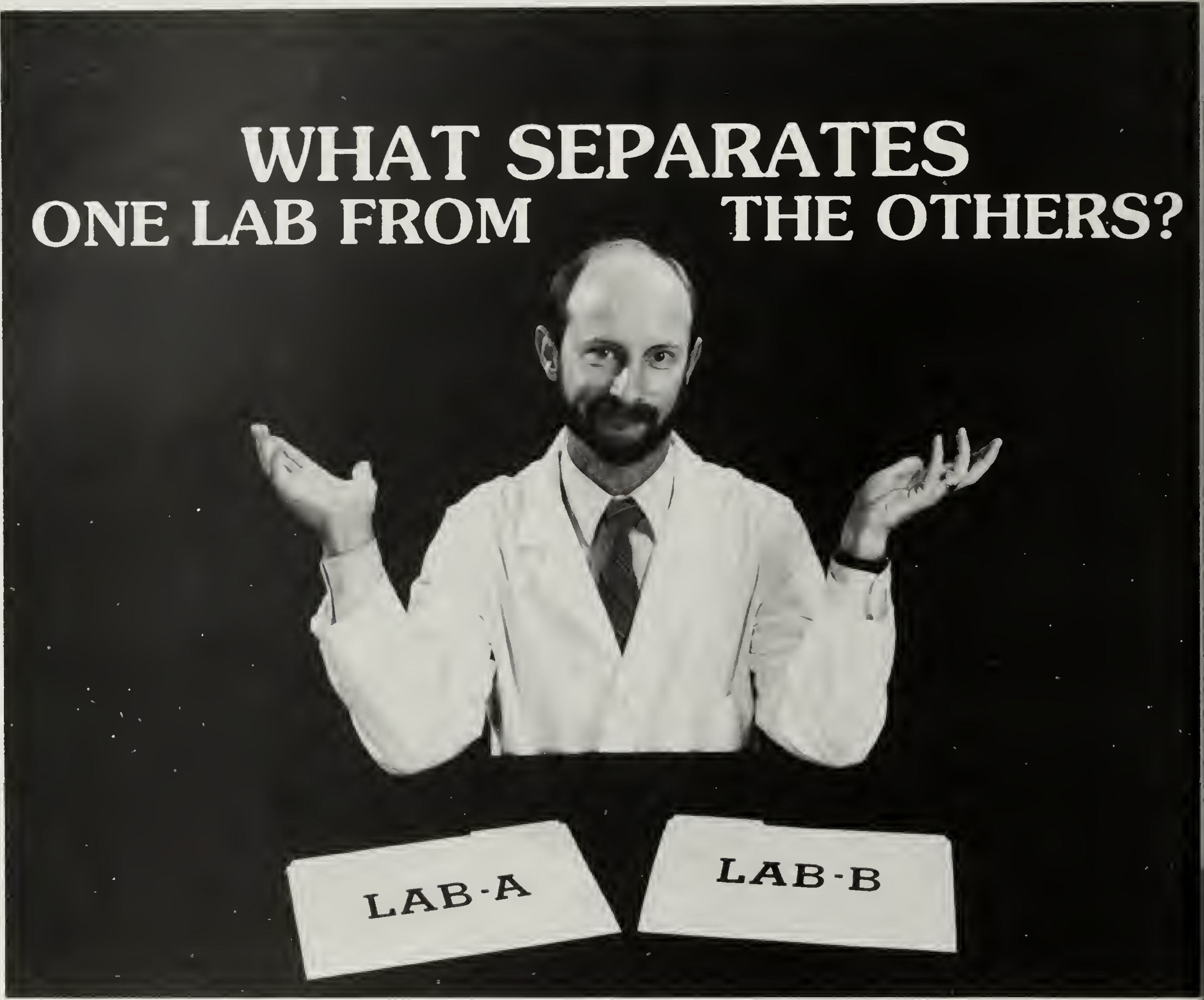

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Michigan Doctors Highlight Women's Hall of Fame

By Ralph D. Ward

The Michigan Women's Hall of Fame, part of the Michigan Women's Historical Center in Lansing, was founded in 1980 to recognize the achievements of notable state women. The 50 current members include four outstanding women physicians. According to MWHOF President Gladys Beckwith "all had in common a commitment, not only to their professions, but to people."

Following is a brief look at these four outstanding women physicians.

Marjorie Peebles-Meyers, MD

Peebles-Meyers

Michigan's medical community has few people with as many firsts. She was the first black woman to graduate from Wayne State Medical School, the first black woman accepted as an intern at Detroit Receiving Hospital, the hospital's first black, female chief resident, and the first to establish an interracial practice in Detroit. Doctor Marjorie Peebles-Meyers was born in New York's Harlem in 1916, in time to be influenced by the area's artistic and cultural renaissance. "To be born there was my one smart move – I had the right city and the right parents" she said in a recent newspaper interview.

Such a combination inspired her to dream dreams thought impossible for a young black girl of her era. After earning high grades at the Harlem public schools, she entered Hunter High School, and then attended Hunter College, earning a degree in physics and chemistry in 1937. Her determination saw her through further college degree work, and in 1938, to the medical school at Washington's Howard University. Marriage to Episcopal priest Frederick Meyers in 1939 was followed by his transfer to a Detroit parish, and her subsequent decision to transfer to Wayne State University. She graduated as the only black woman in her class.

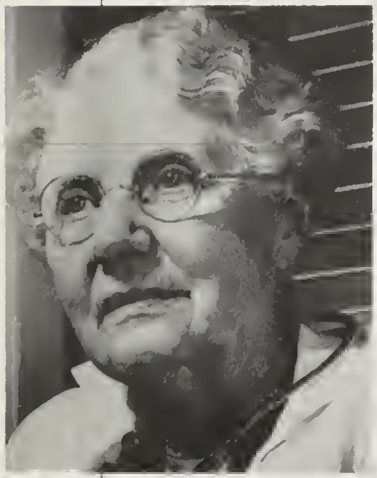
After serving her residency at Detroit Receiving Hospital, Doctor Peebles-Meyers in 1947 entered private practice with Doctor Eugene Shafarman, the city's first interracial practice, and controversial at the time. The support of Shafarman and other colleagues, impressed with her talent and resolve, pressured Hutzel Hospital to become the first area institution to grant her attending status, in 1950. Despite both subtle and overt discrimination, Doctor Peebles-Meyers eventually gained the respect and admiration of staff and patients, black and white.

Over the years, Doctor Peebles-Meyers' growing status, and involvement in community causes, gained her high regard in the southeast Michigan medical community. In 1977, she left private practice to join Ford Motor Company as Ford's chief physician, a position she held until her retirement in 1986.

Bertha Van Hoosen, MD

When Doctor Bertha Van Hoosen was born on the family farm near Rochester, in 1863, there were few options open to country women. The vast majority of bright, rural girls married after a few years of "learning" and disappeared into family life. Yet this was an era of self improvement (the ultimate bootstraps sort, Henry Ford, was born the same year not far away in Dearborn). Doctor Van Hoosen, a bright, determined girl, set out to get a good education, aided by her family. Her father took her by horse cart 13 miles to Pontiac to assure that she went to an accredited high school.

Continued on next page


Van Hoosen

Doctor Van Hoosen graduated in 1879 at 16 and the next year enrolled at the University of Michigan. Although she originally set out to study literature, a meeting with two female medical students inspired her to follow the profession herself. Her parents were shocked, but Doctor Van Hoosen switched majors, graduating in 1884. After a year's residency at Detroit Women's Hospital (now Hutzel), she was qualified, by the standards of 1885, to practice as a physician.

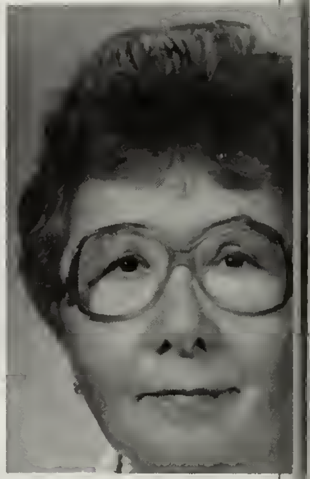
Qualified, yes, but women found little encouragement to go into practice at the time. It wasn't until 1892 that Doctor Van Hoosen was able to enter practice, working in the more liberal environment of Chicago. She succeeded however, in part through her sympathy for the unmet obstetric and gynecological needs of the era's women. Recognition and honor grew for Doctor Van Hoosen over the years, as she became one of the first interns at Cook County Hospital (and eventually Gynecologic Chief of Staff), and in 1919 head of obstetrics at the Loyola University Medical School. In 1915 she co-founded and became first president of the American Women's Medical Association. Still, her family and heart remained in Michigan, and she shuttled back to her home state regularly, practicing surgery at Hutzel Hospital among others. Her memoirs, "Petticoat Surgeon," were published in 1949.

Doctor Bertha Van Hoosen died near Rochester, at the family farm (now a museum in her honor), in 1952.

Clara Raven, MD

The worlds of military medicine and research on Sudden Infant Death Syndrome may seem an odd combination, but to a brilliant physician with the instincts to battle long odds such as Doctor Clara Raven, both are worlds to be conquered. Born in Russia in 1909, she immigrated to the US with her parents, and ultimately graduated from the University of Michigan during the depression. She was the only female student in her class at Duke University Medical School, graduating with her Doctor of Medicine degree in 1938.

The next year found her studying in England, at the University of Liverpool. When war broke out she immediately sought to enlist in the US Army Medical Corps. But not until 1943 were women allowed to enlist, and she became one of the first five female physicians commissioned. Doctor Raven saw service in Europe during the war, as well as in the Pacific, where she served on the Atomic Bomb Casualty Commission. She remained in the Army afterward, and during the Korean conflict conducted research on epidemic hemorrhagic fever. She retired from active duty in 1959, but as a reservist was the first female physician to achieve the rank of Colonel in the Army Medical Corps.


Raven

However, a second career awaited Doctor Raven. In 1959 she was named Wayne County Medical Deputy Chief Examiner. In the 11 years that she held this position, Doctor Raven developed a deep interest in the causes of SIDS. During her tenure, and to the present day, she has advanced the body of research on this malady. She is now retired.

Martha Longstreet, MD

During her career she was perhaps Saginaw's most famous and revered woman, and by far its most beloved physician. Doctor Martha Longstreet gave unselfishly to the community in the first half of this century, and was the definitive pediatrician and family physician. Born in 1870, she trained originally as a nurse, and worked in Saginaw hospitals. Her talents so impressed the hard-to-please male medical community that she was urged to study medicine, which she did, graduating from the University of Illinois Medical School in 1904 with honors. She specialized in pediatrics during post-graduate work in New York and at Harvard Medical School.

Returning to Saginaw in 1904, she gained a reputation for her skill and compassion. She was a member of the consulting staff of Saginaw's three hospitals of the time, and maintained a busy private practice, specializing in pediatrics. Even in an age of house calls and medicine with the human touch, Doctor Longstreet excelled, never missing a house call. She often dealt with the city's poor, operating a billing system that somehow managed to overlook those who could not pay. These patients might also discover a box of food and clothing on their doorstep.

Doctor Longstreet's compassion went beyond her medical practice, prompting her to help corral Saginaw's social programs of the era into a unified Council of Social Agencies. She also founded the city's First Ward Community Center, a clinic for pre-school children. She was designated Michigan's Most Outstanding Woman in 1938. Her achievements are the more remarkable when considering that she suffered from a lifelong handicap, curvature of the spine, at the time essentially inoperable.

Doctor Longstreet retired in 1949, and was presented with a bound testimonial from thousands of grateful patients. She died in 1953, leaving no estate, save for many grateful patients. ■

Longstreet

Ralph Ward is a Lansing-based freelance writer.

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ENROLLMENT STATISTICS

Women make up the highest percentage of medical students in the history of women in US medicine

By Margaret Deirdre McNiven, PhD

In the last two decades the enrollment rate of women entering medical school in the United States increased over 850 percent. While the total physician workforce grew 70 percent between 1970 and 1986, the total number of women physicians increased nearly 241.2 percent (See Table 1, Figure 1). In addition, historical differences in medical practices between women and men have been narrowing over the past two decades. This article explores the history of women enrolling in US medical schools and describes the increased enrollment of women in Michigan's three major medical schools (Michigan State University's College of Human Medicine, The University of Michigan Medical School and Wayne State University School of Medicine).

Distinct differences in the number and proportion of women (16 percent in 1989) and men (84 percent) physicians exist today in the Michigan and the US due to forces that allowed a single digit enrollment quota to exist for women at US medical schools and universities up to 1970. Today women make up the highest percentage of US medical students, residents, fellows and physicians in the history of women in US medicine (See Table 1, Figure 1).

An historical perspective

Women had practiced medicine since ancient times but there had been restrictions on women in medicine in the US. Women were excluded from formal medical education in the US when the first school opened in 1765. The first woman formally admitted to a US medical school was Elizabeth Blackwell in 1847 and the first African-American woman physician, Rebecca Lee, graduated in 1864. By 1870, 0.8 percent of the physicians in the US were women, illustrating the increase in women enrolled at both women's and coeducational medical colleges. The University of Michigan was the first public US medical school to admit women, the first graduating in 1874.

In the nineteenth century, the US had been leading the world in advancing women in medicine. By 1950, there were fewer women physicians in Boston than there had been in 1890. For international comparisons, in 1966 the US had proportionately fewer women enrolled in medical school than any other developed or developing country. The only countries with lower medical school enrollment of women in 1966 were Spain and Myanmar (formerly Burma).

Four factors interacted to reduce the number of women entering medicine earlier this century. Educational and professional reform raised the admission requirements for medical school. These higher pre-admission qualifications were difficult for women to obtain as they largely studied in less competitive all-women schools. Second, the higher standards subsequently effected a 58 percent reduction in the total number of US medical schools from 162 in 1906 to 69 in 1944, so there were fewer medical school positions nationwide.

Third, the number of schools especially for the woman student, decreased. Some women's colleges merged with other schools, some closed altogether due to an inability to meet the nationwide higher academic standards, and other medical schools became coeducational.

Fourth, there were few places assigned to women in the coeducational medical schools. It became increasingly rare for women to achieve admission to the dwindling places in medical school. Early in the twentieth century women physicians watched the doors through which they had passed all but close behind them.

Enrollment of women (See Table 1, page 25) doubled at US medical schools in 29 years (1920-1949) but tripled in just five years (1970-1975). The rate of increase had slowed in the 1980s (See Table 2 on page 27). At Michigan's three medical schools the first year enrollment of women in the past 15 years increased 50 percent (See Table 2) at rates always higher than the national average of first year enrollment of women.

Most of the impetus for change for women came from outside medicine.

Shortage of physicians

Temporary shortages of physicians and of male medical school applicants in the US occurred during the two world wars. Medical schools then admitted more women either by increasing the women's portion of a coeducational medical school or by eliminating a men-only student tradition. Postgraduate internships also opened to women during World War II because hospitals were understaffed.

Another shortage of physicians occurred in the 1960s due to a rapidly expanding population with no increase in the physician supply. Women were then actively sought to enter medicine.

Encouragement of women

There were several other factors in addition to the physician shortage that enabled more women to enter medical school in the 1960s. Societal attitudes increasingly encouraged women into a broader range of career options. More women had the academic preparation for medical studies after passage of the 1958 National Defence Act which promoted scientific training. Further, the American Medical Women's Association with the Women's Bureau of the Department of Labor, sponsored a conference in 1968 to encourage women to enter medicine.

Removal of formal barriers

In 1970, the Women's Equity Action League filed sex-discrimination suits against all US medical schools. That same year, a resolution on equal opportunity adopted by Assembly of the Association of American Medical Colleges (AAMC) led to annually increasing proportions of women accepted into medical school. The federal government prohibition of sex discrimination and affirmative action requirements were also influential on medical schools and their universities. The US Government requires compliance with these laws to receive federal funds such as student financial aid, research grants, and special program funds.

Lowering of informal barriers

Because medicine had been a male-oriented and a male-controlled profession it was implicit that men were suitable but that women were not suitable for a medical career. Discrimination that favored male physicians by employers, patients, society, and the profession has shaped the professional experiences of women physicians. There had been a greater acceptance of

Continued on page 27

Table 1

Women Medical Students and Graduates 1894-1990

Year	Women Students	% of all Students	Women Graduates	% of all Graduates
1894	1,419	*	144	*
1904	1,129	*	254	*
1905	1,073	*	219	*
1906	895	*	233	*
1907	928	*	211	*
1908	835	*	185	*
1909	921	*	162	*
1914-15	592	4.0%	92	2.6
1919-20	818	5.9%	122	4.0
1924-25	910	5.0%	204	5.1
1929-30	955	4.4%	204	4.5
1934-35	1,077	4.7%	207	4.1
1939-40	1,145	5.4%	253	5.0
1944-45	1,352	5.6%	262	5.1
1949-50	1,806	7.2%	595	10.7
1954-55	1,537	5.4%	345	4.9
1959-60	1,710	5.7%	405	5.7
1964-65	2,503	7.7%	503	6.8
1969-70	3,390	9.0%	700	8.4
1974-75	9,786	18.1%	1,706	13.4
1979-80	16,141	25.3%	3,497	23.1
1984-85	21,316	31.8%	4,904	30.1
1989-90	23,513	36.2%	5,231	34.0

Note

Data for years 1949-1957 are from "Women in Medicine Statistics" by AAMC, 1988, Copyright AAMC, Adapted with permission from AAMC.

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women physicians within the medical profession and by patients.

Medical school barriers

Higher education permitted this sex discrimination through the medical schools' acceptance systems based on a single-digit quota for women medical students (See Table 1.). Between 1930 and 1966 the number of women applying to medical school had increased 300 percent but their acceptance rate actually fell while men's application rate increased only 29 percent. Counselors advised eligible women students against applying or re-applying to medical school as did women's families.

Performance in medical education

The performance of men and women from the first year of medical school through the first year of postgraduate study and board examinations was virtually equal. Since 1970, the drop-out rates were the same for women and men in medical school. Also the stop-out rates from medical training and practice for women physicians, primarily for childbirth, were shorter than previously believed, limited to weeks or a few months.

Financial barriers

The high cost of medical education was a deterrent to women, especially for older applicants. The observed inequities in income and promotion for women physicians may also have deterred women from entering medicine.

Stress as a barrier for women

Women's sense of isolation in medical training added to the stress of preparing for a medical career through the following: their minority status; the stereotyped identification of the physician as an aggressive, competitive, scientifically astute man; and finally, due to the low representation of women role models and mentors in the medical training environment. Specific offices for women in medical schools have facilitated the success of women medical students as sources of support, and redress when necessary.

Osteopathic colleges

The comparable figures for the osteopathic profession were a 1986 first-year enrollment of 28 percent women and 25 percent of 1986 DO graduates were women. These are lower figures than for the MD schools but in the same increasing direction. The DO impact was small on the national pool of women physicians as DOs were only 4.2 percent of all active physicians in the US in 1986. However, in 1985 DOs were 17 percent of physicians in Michigan, so the impact will be greater in Michigan as women are an increasing proportion of DOs. Michigan State University's College of Osteopathic Medicine claims the highest enrollment of women among all 15 US osteopathic colleges (personal communication).

Summary

Women were 15.2 percent of all US MD practitioners of medicine nationwide in 1986 (See Table 1.) and 16 percent of all non-federal physicians in Michigan. In 1990, 39 percent of all US MD first-year medical students and 34 percent of all MD medical school graduates were women (See Tables 1 and 2). In Michigan in 1990, 42 percent of MD first-year medical students were women (See Table 2). It is important to study the professional activities of the woman physician as she is contributing an increasing proportion of medical services to the US. By 2010, it is projected that 30 percent of all physicians in the US will be women. ■

Professor McNiven is former coordinator of the Michigan Medical Schools Council of Deans.

Table 2

Enrollment of Women in Michigan and US Medical Schools, 1975-1990

	MSU		U of M		WSU		Michigan Total	USA Total
Year	n	%	n	%	n	%	%	%
1975	39	37%	69	29%	55	21%	26%	24%
1980	49	46%	50	21%	66	27%	28%	29%
1985	51	48%	49	26%	70	27%	32%	34%
1990	58	53%	77	37%	109	41%	42%	39%

Note: Michigan State University's College of Human Medicine, The University of Michigan's Medical School, and Wayne State University's School of Medicine. Data for Michigan's medical schools are from the *Dean's Fact Book, Michigan Medical Schools Council of Deans Annual Report*. National data for years 1975 - 1990 are adapted from *Final National Admission Action Summary Reports* by AAMC, 1990.

Spouses of female physicians encouraged to join MSMS Auxiliary

By Lois Germain Duhamel
MSMSA President

September has been designated "Women in Medicine Month" by the American Medical Association as a means of promoting and recognizing the many contributions of females to medicine. Female physicians now number one in five, and their ranks are expected to swell to approximately 30 percent of the physician population in another 20 years. In some schools the freshman medical classes are nearly half female, while the national average of female medical students is now approaching 40 percent. The medical society auxiliary is the only organization that in order to be a member, one must be the spouse of a physician.

I would like to extend an invitation to the spouses of the female physician members of the Michigan State Medical Society to join our auxiliary ranks. While men make up a small percentage of our membership at present, the number is growing. The auxiliary is a unisex organization. We are no longer a "tea and cookie, fashion show" group. We are an action organization which functions as the public relations component of the profession of medicine. We work on the local and state level to improve the image of physicians, our spouses. We engage in fundraisers for AMA-ERF and other worthwhile health-related causes. We have become a potent political force, both in actively campaigning for candidates who are friendly to medicine, and in becoming "key contacts" for the many serious medical issues that are being considered by these elected legislators, senators, and congressman for whom we have worked on their campaigns. Many of the male spouses who have joined the auxiliary in recent years are especially interested and active in the organization's legislative activities.

All of these are activities in which the spouses of female physicians can engage and make a meaningful contribution. Many male spouses are also professionals — lawyers, educators, accountants, businessmen — who have challenges and problems similar to those of the medical profession. The auxiliary can certainly benefit from your expertise, how you have solved problems within your professions, to bring us a fresh outlook for solutions to many of medicine's problems.

What the Auxiliary needs most are individuals who are dedicated to doing all they are able to improve the appreciation and perception of your physician-spouses (be they male or female) by their patients, the legislators, and particularly the general public.

William Madigan, MSMS executive director, and spouse of Marsha Milburn, MD, and Martin J. Adelman, professor, Wayne State University Law School and spouse of immediate past-president Susan Hershberg Adelman, MD, are both Auxilians. If you are interested in obtaining more information or if you would like to join the MSMS Auxiliary, please contact Dawn Reha, MSMS-A executive secretary at (517) 337-9653. We offer support and understanding that no other group can. Physicians' spouses face issues that no one else does, because they are married to professionals who face life and death issues on a daily basis. If we don't care, who will?

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Michigan's Leading Women in Organized Medicine

The Michigan State Medical Society serves as a stage for physicians who choose to participate in organized medicine. Here are some of the women physicians who have leading roles in MSMS, the AMA, or their component or specialty society. The following brief sketches have been compiled from information sent by the individual physicians.

TAMA D. ABEL, MD

A graduate of the University of Michigan Medical School, Doctor Abel serves as an emergency medicine physician with the Jackson County Emergency Service, PC, Jackson. She has been active with the MSMS Committee on Concerns of Women Physicians and the MSMS Young Physicians Section, which she currently chairs. She is also active in the AMA, the Washtenaw County Medical Society, and both the American and Michigan Academies of Family Physicians.

SUSAN HERSHBERG ADELMAN, MD

A graduate of the Wayne State University School of Medicine, Doctor Adelman is a pediatric surgeon in private practice in Detroit and Dearborn. A member of the MSMS Board of Directors, she has held numerous MSMS posts, including president in 1990-91 – the first woman to head MSMS in its 125-year history. She currently chairs the MSMS Task Force on Environmental Health and the MSMS Chemical Dependency Focus Group. She is an active member of the AMA, the Wayne County Medical Society and several specialty organizations.

CATHY O. BLIGHT, MD

A graduate of the Michigan State University Collge of Human Medicine, Doctor Blight is senior associate pathologist at Hurley Medical Center, Flint. A member of the MSMS Board of Directors, Doctor Blight is an active member of several MSMS committees, including Membership Recruitment and Retainment, Legislation and Regulation, the Task Force on Professional Liability and the Michigan Doctors Political Action Committee. She is an active member of the AMA, the Genesee County Medical Society and several specialty groups.

RHODA M. POWSNER, MD

A graduate of the Yale University Medical School, Doctor Powsner is a cardiologist in private practice in Ann Arbor. She has long been active on the MSMS Ad Hoc Committee for Implementation of Arbitration – a committee she currently chairs. She is an active member of the AMA, the Washtenaw County Medical Society's Executive Committee, and several specialty organizations.

MARGUERITE R. SHEARER, MD

A graduate of the University of Michigan Medical School, Doctor Shearer is an Ann Arbor family physician and clinical assistant professor of family practice at the U-M Medical School. A member of the MSMS Board of Directors, Doctor Shearer is actively involved with the Washtenaw County Medical Society, the AMA and several specialty organizations.

Times are changing for the better

By Susan H. Adelman, MD

One of the major parts of my life has been organized medicine. When I first became active, I was still building my practice, and my self confidence grew as I learned how my profession works, first through the Wayne County Medical Society, then MSMS, finally the AMA. Before I start talking about MSMS or the AMA though, let me tell you some tales from when I started, before I reached where I am now.

When I was a hard-working junior resident, a senior resident noticed me struggling with a patient care problem in the middle of the night, and he asked, "What are you doing here when you could be at home making somebody happy?"

When I was a young surgeon starting out in practice, a pediatrician who referred me hernias sent a newborn with a diaphragmatic hernia to another pediatric surgeon at 2 a.m. one night. I found out about it later that week. The next time I saw him I asked why. He said, "Oh Sue, do you really want to get up like that in the middle of the night?"

When I was building my practice a young female pediatrician sent me hernias, but no major bowel surgery. I asked why. She shuddered and said "Oh, I don't know how you do it. I would be so scared to go in there and operate like that!"

Today, pressure to change our medical system is building up in the US. The AMA can only be powerful in its negotiations with government if it represents all of medicine, including women.

Women are now approaching 40 to 50 percent of our medical school classes, no longer the seven percent in my class. Women represent 15 percent of the profession, soon to be 30 percent. When I started, there were six or eight female pediatric surgeons in the country, only one or two of whom had both a husband and children. Now we have some 50 women, and young residents walk around pregnant, cheerfully planning how to juggle surgery, children, job, and home.

At my first AMA meeting, the House of Delegates had perhaps five women. Now there are 50, with four women on the Board of Trustees. When I was elected president of the WCMS, it was a first in Wayne County, now female county presidents are common. When I was elected president of the MSMS, it was a first for Michigan, and there had been only a dozen in the country, almost all since 1979. Now we run about two a year. Times are changing!

As some things change though, some remain the same. A senior surgeon initiated a surgical caucus of some 180 surgeons in the AMA House of Delegates. At the second meeting, I was elected vice-chairman. The background is that I had laryngitis, and I could only conclude that apparently there is nothing that a room full of 180 men likes better than a woman who cannot talk.

Now there are Women in Medicine Committees in state medical societies, county medical societies, and many specialty societies. I am on the AMA Advisory Panel on Women in Medicine. These committees help move women into leadership positions, but we do not want to be singled out as speakers mainly for "women's issues." If we allow ourselves to be pushed into that role, we will start moving backward again.

One thing we should address is the earning differential between women and men in medicine. Even taking into account the age and specialty choice differentials between us, age-matched groups of women earn some 30 percent less than men in the same specialties. Women may have different priorities, such as spending more time with each patient. Women do seem to be sued less, though this has not been fully documented.

Maybe if there had been more women in medicine way back, there would have been more doctors spending time with patients, with lower earnings and fewer suits. Maybe with more women in the system, we would not have the pressure to change our health care system that we have now. ■

"Maybe if there had been more women in medicine way back, there would have been more doctors spending time with patients, with lower earnings and fewer suits."

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Didn't the elves come last night?

The challenges of balancing career and family

By Eva Youshock, MD

I like to consider myself typical of the new wave of women in medicine. I'm a wife, a mother, and an active practitioner of dermatology. In addition, I've just opened a new solo practice. Everyday I struggle with the demands of fulfilling other people's needs while trying to get everything done, like being there for my kids, husband, and my patients. At the same time, I have to deal with all those trivialities like dinner, the laundry, and housecleaning. I'd love to delegate many of these things to someone else, but that someone just never comes along.

"Didn't the elves come last night?" I ask my husband as we walk into the kitchen. Dirty pots and pans are stacked on the counter, and the dinner dishes are still on the table. I'm not going to let this 6 a.m. mess get me down. I'm still pleased with myself for having cooked a complete, nutritionally-balanced dinner from scratch. (None of those sodium-rich canned or frozen products for my family!)

We had tried to get a housekeeper. Yes, remember Hazel from TV? Or better still, Alice of "The Brady Bunch"? Well, those women are extinct. So, we just have a dirty house. I always want to clean it, but that just doesn't progress on my list of priorities. Being chronically behind, that's the way it has been since internship. The least hectic time of my life, thinking back to college, was probably senior year of medical school. Things haven't gotten any less busy over the years. Until I recently started working part-time, I used to use my vacation days to catch up on "the rest of my life." Even now, with working part-time, I still cannot find the time to write that letter to the editor or read that book I've been wanting to read.

Continued on page 35

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I at least now have someone to help take care of the girls. By the time it came to interviewing for the young lady we have, I had whittled my "wish list" down to the point that I didn't even think of asking if she could possibly get dinner started, or quiz her abilities regarding doing the kids' laundry. I was just so happy to get someone who was willing to be flexible about our hours and who had some experience taking care of kids.

Having a nanny has freed me up to practice medicine without incessant worries and conflicts. Now, if one of the girls is ill, it isn't a major logistical feat getting her to the pediatrician's office. It's wonderful having the freedom on my "day off" to "go places" (interpretation: run errands, see hospital consults, and hold business meetings). Yes, I love working, and would never hack it as a stay-at-home mom. Sometimes I wonder if I shouldn't be more involved in domestics and mothering. That's probably a constant issue for many female physicians. For myself, if I did less medicine and more of my husband's shirts, I wouldn't be as self-fulfilled and therefore wouldn't be as good a wife and mother as I am now. (Speaking of shirts, I am lucky enough to be married to an independent '90's man who will do his own.)

Proud to be a physician

I'm proud to be a physician and a mother. I worked full time during my first pregnancy, and for the most of my second. I wish I could brag about how easy it was, but I can't. I had the 24-hour variety of "morning sickness," and had it well beyond the typical 12 weeks. I managed to get through it, though. Like, I was somehow able to do all my vomiting in between patients, and only had to leave surgery once, in the final few sutures. I saw as many patients as I could in my office instead of the exam room, since relative immobility made it better. I took naps on my exam table during lunch hour. I went from morning sickness to a near constant heartburn, but that could at least be managed with antacids, the worst part being a constant vigil for chalky lips. I don't think I was as good a physician from the personable standpoint as I usually am; it was hard to be upbeat and completely attentive when I was concentrating on not throwing up. My only negative evaluations came during these times, but I think my patients would have been more sympathetic if they knew, because all of them were so protective and caring when my pregnant state was obvious.

Both of my daughters were born well beyond their due dates. With the first, I returned to work during my scheduled time off because staying home awaiting her arrival was driving me crazy. With my second, I was so short of breath from being so large that I appreciated the rest period. Childbirth went really well for me. I was proud that I managed to do it completely naturally, without any medication.

I nursed my first child, without supplements, for 11 months while working full time. (My second was nursed for 10 months, also without supplements, until she suddenly declared her independence on Mother's Day.) It was not nearly as difficult as many people think. I prepared for my return to work by hoarding all the milk that was so abundant during maternity leave, necessitating the purchase of an additional freezer. It was a bit tricky handling breast pumping at work, but I was able to time it so that I needed only one break period a day. This was a hallowed break, no add-ons or drug reps during this time. But I nearly always did paper work through these "breaks," part of that chronically being behind thing.

Supportive husband helpful

As for marriage, sometimes it clashes with the practice of medicine, competing for scarce time and attention. Instrumental to my successful marriage is a flexible husband who does not carry a mantle of preconceived male-female roles. Also a physician, he does not consider his job more important than mine. David did all the food shopping when my second pregnancy drained me like a chronic illness. He cooks, cleans, changes diapers, feeds the girls, and does laundry, in addition to being Mr. Fix-It and paying the bills. To sum it up, he does all the things I do, and more.

Currently I am letting my husband support me financially while I get my practice off the ground. I got the idea for it while home on maternity leave. Several of my physician friends thought I was crazy. Was it crazy to leave an institution where I was financially secure, had defined working hours, and managing the staff was someone else's problem? Not in my estimation. I wasn't being nurtured there, nor did I feel that my voice was being heard. (Or was it just being ignored?) Although it probably had more to do with the size of the institution, being ignored as a female voice was something I had noticed there as a resident. It had since become a recurrent theme.

My residency training program was excellent, and was about half female. Although we female residents had many excellent ideas and suggestions, none of them ever seemed to get implemented. Any persistence on our part was viewed more as a nuisance than a help. (It seems males are complimented for their assertiveness and innovation, while females are derided.) Despite our being as or more knowledgeable, our male peers were chosen for all the privileges, such as running the

Continued on page 36

laser program, or choosing the departmental camera. They had reduced clinic hours to do these things, too, while we were the workhorses. We were left with the satisfaction of how well we managed to cope and keep things running smoothly.

Few female role models

Throughout all this there was almost no female support or female role models for us. Although there were two female staff in the department, they didn't offer anything other than basic dermatologic teaching. If it weren't for two dermatologists that I knew from medical school, who served as mentors then and now, there would have been no one for me. (It turns out that both had attended Smith College, my all-female alma mater, and which added to the continuity.)

I am very sensitive about this lack of female role models. I've joined various women's medical societies as much to find role models as to be one. I have always tried to be particularly helpful to female medical students and residents I've worked with along the way, so that they won't have to feel this void. Yet I am surprised at how apathetic they are about being involved in women's societies; many women are rather resistant to the whole idea of them.

Perhaps we could get along fine without role models if women could step into positions of authority in the same unquestioning way that men can. Here is where I have really felt a distinct difference being a female physician. I never felt prejudice from patients, although I had rather expected it along the way. No, the prejudices have come from ward clerks, technicians, and nurses, who seemed to feel that orders coming from a female physician carried less weight than a man's, or perhaps weren't orders at all. Or that those orders were subject to question, dispute, argument, or to simply being ignored. I'm really starting to get tired of it. (I haven't escaped it yet in private practice, but now I have a choice not to tolerate it. Afterall, I am the employer, and I have the power to fire.)

My experiences as a female physician patient have made me especially aware of the different levels at which male and female doctors are viewed. I just cannot imagine any nurse or technician treating a male physician as I was treated during several encounters as a patient. Nor can I imagine a male physician tolerating it the way I did. But that is another story. Perhaps I'll write about it someday, when I'm less busy. In the meantime, I have to go make dinner.

Doctor Youshock is a Rochester Hills dermatologist.

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Insurance Commission Report on the Blues Reversed By Special Hearing Officer

By Thomas R. Williams
Kerr, Russell and Weber

In a lengthy opinion critical of both Blue Cross and Blue Shield of Michigan and a former acting Michigan Insurance Commissioner, a special hearing officer has reversed a report by the Commissioner approving the Blues' Provider Class Plan (PCP) for 1987-88. In the opinion, issued August 5, Robert Borsos, a former Kalamazoo County Circuit Court judge, ruled that the Blues failed without good reason to meet the goals of access, quality and cost – all mandated by Public Act 350 of 1980. Act 350 is the legislative framework within which the Blues must operate.

Borsos also ruled that the controversial 1990 Physician Participation Agreement (PPA-90) was not properly implemented by the Blues. He found that the Blues had mailed the agreement to Michigan physicians six months prematurely, without the benefit of public hearings, in contravention of PA 350. Despite this finding, Borsos specifically declined to invalidate PPA-90. He comments: "PPA-90 was conceived long after the close of the period under review and should not be considered in determining whether BC achieved the statutory goals for the years 1987-88."

The Borsos ruling resulted from an appeal by various physicians who disputed the validity of a 1990 determination by former acting insurance commissioner Dhiraj Shah approving the Blues PCP. Under Act 350, Blue Cross is accountable to the Insurance Commission and must demonstrate by way of its PCP that it is meeting goals of making quality health services widely accessible at reasonable costs. If the goals are not met, the Blues may demonstrate good reasons for not meeting them. Borsos conducted a six-month hearing and reviewed voluminous documentary evidence. Blue Cross was not actually a party to the litigation which was between the physicians and the Insurance Commissioner. The Blues were permitted to intervene.

The opinion, which is colorful, colloquial, and at times rambling, is divided into four sections. Part I deals with the Commissioner's Determination Report (D/R) on the PCP. Borsos analyzed the D/R and concluded that it clearly demonstrates on its face that not one of the three statutory goals was met by Blue Cross. Borsos went so far as to say that this conclusion was so apparent that six months of trial could have been avoided if he had known enough about the health care business at the outset to intelligently analyze the D/R. Borsos observes: "It is difficult to understand from reading the D/R why it contains so many reasons for failing BC and yet ends up giving BC a passing grade." He likens the Commissioner to a schoolteacher who passes a failing student onto the next grade with a mere admonition to study harder. Borsos says the Commissioner was acting more like a "college professor making a study of BC" but should have been the policeman on the beat, equipped with a badge of authority, a gun and handcuffs to apprehend wrongdoers immediately..."

The second section of Borsos' opinion is a lengthy commentary on the issues and evidence presented in the hearing itself. He sides with the physicians and against the Blues on virtually every issue. Borsos criticizes the Blue Cross appeal process. He says the Blues' use of statistical sampling may be

Continued on next page

Continued from previous page

a "great time-saving way to count beans" but "is not fair for an evaluation of a doctor's medical practice." He maintains statistical sampling actually injects "gross error into the records of doctors who may be practicing good medicine."

Borsos is also harshly critical of the "retaliation" by the Blues in the form of an "outrageous remedy" of 100 percent withhold following audits. He also criticizes "secret" fee screens used by the Blues in 1987 and 1988 and the unilateral denials made by the Blues in medical necessity cases. Borsos defers to the treating doctor as being in the best position to make determinations of medical necessity. Borsos also elaborates upon the failure of the Blues to provide effective channels of communication with physicians.

In Part III of the opinion, Borsos concludes that Blue Cross violated Act 350 when it rushed the 1990 physician agreement into the hands of physicians six months ahead of the statutory timetable. He concludes that the obvious reason for the haste was to achieve quick action "necessary to stem a growing resentment among MD Providers" over the contract.

Borsos' comments are strong but his opinion appears to offer little practical remedy for physicians, at least as to the 1990 physician agreement. Nearly buried on page 18 of the opinion, is Borsos' telling observation: "I have no power to fine BC, or give judgment against BC, or enjoin its actions, even if I think the actions are mistaken – and I think PPA-90 is and was a mistake, at least in its timing."

As a result of the Borsos decision, however, PPA-90 may have to be modified by the Blues within six months of the decision as part of a new provider class plan. Borsos' opinion did in fact specifically adopt be reference the legal arguments submitted by the physicians in their final position paper in the case. The physicians' positions on the issues of appeals, level of reimbursement, and determination of medical necessity, for example, cannot be reconciled with corresponding provisions of PPA-90. Since PA 350 makes the Blues' participation agreements part of their provider class plans, changes to PPA-90 may be required to comply with a revised PCP acceptable to Borsos.

In the final portion of his opinion, Borsos levels his criticism directly at the Commissioner for rejecting the recommendations of his own staff regarding the Blues' attainment of its goals. Although Shah's staff had determined that the Blues had unreasonably failed to meet all of its goals, in the final D/R, Shah concluded that the Blues had actually achieved the access and quality goals and, although the cost goal was not achieved, the failure was reasonable. Borsos concludes that Shah was faced with a D/R that was overdue. "He faced the dilemma of how, in a short time he could help BC. There was no time to gather more facts which might help BC make a better showing so he just changed theory." The staff's words pointing out failure were changed to mere recommendations for change.

Borsos' commentary makes clear that the Commissioner's actions were not in the best interests of the people of the State of Michigan. "I would expect," writes Borsos, "that the Commissioner took an oath of office when he was appointed and that the oath included an obligation to protect the people of this state. That's what regulation is all about. The Commissioner might be on friendly terms with top BC people but when he is reviewing BC's performance, he should be like Caesar's Wife."

In reversing the Commissioner's Determination Report, Borsos has ordered Blue Cross to submit a new provider class plan within six months. The new PCP must substantially achieve all statutory goals, and it must overcome the deficiencies cited by Borsos and by the physicians in their position statements.

With respect to the 1990 Physician Participation Agreement between Blue Cross and thousands of Michigan physicians, Borsos makes clear that it remains valid and in force. Based upon Borsos' adoption of the physicians' positions, however, fundamental aspects of PPA-90 may have to be revisited and revised by the Blues within six months of the decision.

Because the special hearing and decision by Borsos are unprecedented, it is not yet clear what, if any, appeal rights Blue Cross may have. On September 3, the Blues filed an application for leave to appeal with the Michigan Court of Appeals. Regardless of the ultimate outcome of the case, one practical result of the Borsos ruling may be greater flexibility and communication by the Blues it its dealings with physicians.

Editor's Note: MSMS will continue to inform members of development in this important case. BCBSM must file its request for an appeal by early September. MSMS will discuss the decision with BCBSM Board members and management at a September 10 meeting of the BCBSM Physician Contract Advisory Committee. The MSMS Board of Directors will discuss potential implications of the decision at its September 11 meeting. We will report on the decision in Medigram throughout September and as developments occur.

When Adding Subtracts

Adding interest charges isn't the best way to collect on overdue bills

By Randall W. Braaksma

Everyone expects to be paid for work done. When you're not, frustration sets in. Some physicians remedy the situation by adding an interest charge to overdue bills. This approach is legal (see sidebar on page 40) and has one benefit – your patients are familiar with this language; they've heard it before from banks and credit card companies.

The question is whether you want your patients to think of you as a lending institution. Psychologically, this might have the opposite effect. Rather than prodding your patients to pay, interest charges may cause them to put off paying. Or, interest charges may simply offend your patients.

On the other hand, not pursuing overdue accounts may make you popular with patients who are delinquent on their payments, but it won't do your practice – or your patients – any good. "It's to everyone's advantage when a physician runs his or her practice like a business," says Lansing- based practice management consultant John Anthony. "The doctor benefits by controlling operating costs which in turn means he or she doesn't have to raise prices for patient services."

"Having to add interest charges in order to recover delinquent accounts probably indicates poor collection practices," adds George S. Conomikes, president of Conomikes Associates, Inc., a practice management consultant firm headquartered in Los Angeles, Calif., that conducts practice management seminars for MSMS in Michigan.

"Practices that have trouble collecting payments," he says, "usually fall down in two areas. First, they don't do a good job of explaining to their patients up front exactly what the practice's payment policies are. Second, they don't do a good job of following up by telephone after the second statement has been sent and no payment received."

Telling patients how to pay

Each physician must decide the best way to ask his or her patients to pay. But once they decide, all physicians should clearly tell their patients. Problems with overdue bills can be alleviated by letting patients know before they receive treatment just what your payment policies are.

Many physicians have found that a patient information brochure is the perfect place to communicate these policies. A brochure is especially useful in introducing new patients to your practice. If you don't have a patient information brochure now and you'd like guidance on how to proceed, contact the MSMS Communications Department at (517) 337-1351. Its staff can advise you on how to go about developing your own brochure.

Offering credit card payment

Obviously, asking patients to pay at the time of service is most desirable. You can make that easier – and more attractive – to them if they can pay by credit card. This approach has the benefit of ensuring you that you'll receive your payment for services rendered. If there are problems with collection, they will be handled by the credit card company.

MSMS endorses a merchant credit card program through Comerica Bank that uses VISA and MasterCard. The system can operate over the telephone lines, or you can install a point-of-sale terminal which will give your patient a receipt for the transaction on the spot.

For more information about the merchant credit card program, contact Dawn Reha at (517) 336-7570. She is an account executive at Physician Service Group, Inc., the MSMS subsidiary that provides services and programs to member physicians.

Continued on next page

Continued from previous page

If your situation doesn't permit requiring patients to pay at time of service, you may be encountering difficulties collecting on some overdue bills. If the telephone follow-up Conomikes recommends isn't bringing results, here are two other alternatives.

Adding a service charge

Since the legal limit on interest charges for overdue bills is so low (barely one-half of one percent a month), an interest charge on a large account, say for a surgeon's services, won't amount to much, to say nothing of the impact on the larger in number but smaller in size accounts that, say a pediatrician, typically handles.

A service charge of between two and five dollars on a bill that's over 60 days old will probably have a greater impact. Physicians arrive at their service charges by analyzing their costs to issue a statement. Conomikes recommends that you document how you arrive at your service charge, since under Title III of Public Law 93-495, Fair Credit Billing, your patients can ask you to demonstrate how you arrived at your service charge.

The costs to issue the first statement are part of your normal costs of doing business. Every time you must issue another statement you incur extra costs. Adding a service charge on bills 60 days past due may both prod the patient to pay and recover the costs of issuing another statement.

Two to five dollars added to a patient's bill is often enough to move someone to action. According to Bob Harper of IC System, a collection agency, "most people who are behind on their bills don't have chronic debt problems. There's usually a reason why they haven't paid – they've been too busy, they've forgotten, they've been waiting for an insurance payment. Once you remind them, they are usually eager to clear things up."

Using a collection agency

While most people are ready to pay the debts they owe once they've been reminded, you shouldn't have to remind them more than once. The second reminder means that the bill is already 60 days old.

Only you can decide when a debt becomes a bad debt, but you should realize that debts on your books depreciate at between seven and nine percent a month. Carrying debts on your books not only means that you don't have the money that is owed you but also that the money is losing value every day you don't collect.

Some physicians turn bad debts over to a collection agency, usually as a last resort. This relieves your office of the hassles of continually following up on outstanding bills. The cost to you varies. It's usually a monthly fee based on the number of accounts you're asking the agency to collect.

There are risks to this approach, however. You must make sure that the collection agency you choose is professional. Stiff-arm tactics may get you your money, but they will lose you your patients. IC System, for example, has earned an MSMS endorsement both because of the professional way it handles collection and the experience it has working with doctor's and dentists' patients. (see sidebar on page 40)

In an ideal world, everyone pays his or her bills. In the real world, some don't. How you approach payment policies in general and overdue bills in particular can have a big impact on your peace of mind, to say nothing of your ability to manage your practice efficiently and to provide quality health care at reasonable prices. ■

Randall Braaksma is an East Lansing-based freelance writer.

Interest charges are legal

If you choose to add interest charges to overdue bills you are within the law, according to MSMS Legal Counsel Richard D. Weber. He cites the State Attorney General's Opinion No. 5809 issued in 1980 which says that "A professional corporation or a professional person, such as a dentist, may enter into an agreement for the payment of interest to compensate for delayed payment of a bill for professional services rendered, but the maximum rate of interest charged may not exceed five percent per annum unless the parties agree in writing to an interest rate not in excess of seven percent per annum. A professional corporation or a professional person, such as a dentist, as an alternative to charging interest, may offer to the patient a cash price or a higher time-price differential arrangement for professional services to be rendered." In either case, *consult with your attorney before you proceed.*

What's an MSMS endorsement?

"It's a cross between the *Good Housekeeping* Seal of Approval and a UL listing," says John Richards, general manager of MSMS Subsidiary Operations. He explains the process of endorsement this way: "Businesses are constantly approaching us with products and services they want us to endorse so physicians will feel comfortable buying them. We have a responsibility to check them out thoroughly. We talk to other professional organizations who have used the products or services. We ask clients who have used them. And we rely on the doctors who sit on the MSMS Board for their opinions. When everyone's satisfied that the product or service does what it says it will and provides value for the investment, and that the company that offers it is stable and committed to the long haul, then MSMS gives its endorsement."

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- Generates aged accounts receivable reports
- Generates referral reports
- Generates additional financial and management reports

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MEDICAL INQUIRER

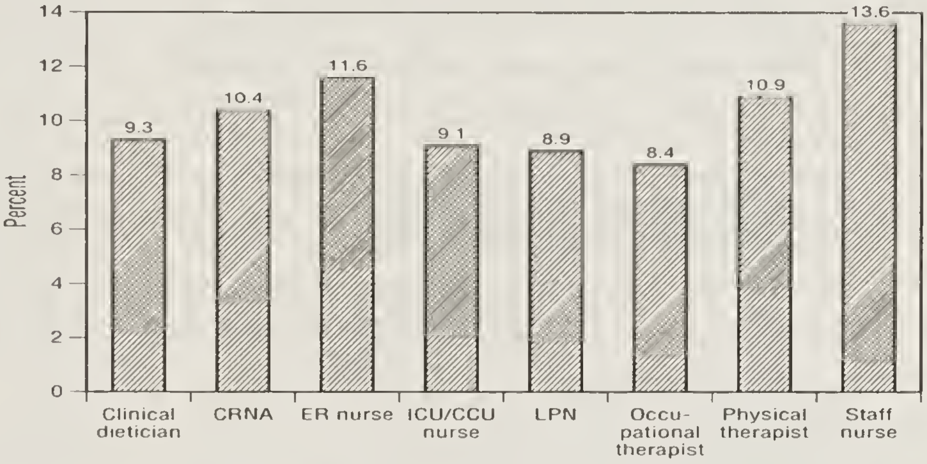
DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS

Health Personnel Shortage Survey

Michigan Hospitals have been struggling with personnel shortages for several years, and anecdotal information suggests that the problems have intensified recently. The Michigan Hospital Association conducted a survey of hospitals to establish vacancy rates for various positions and across regions of the state. The following 1990 data represent responses from 69 community hospitals.

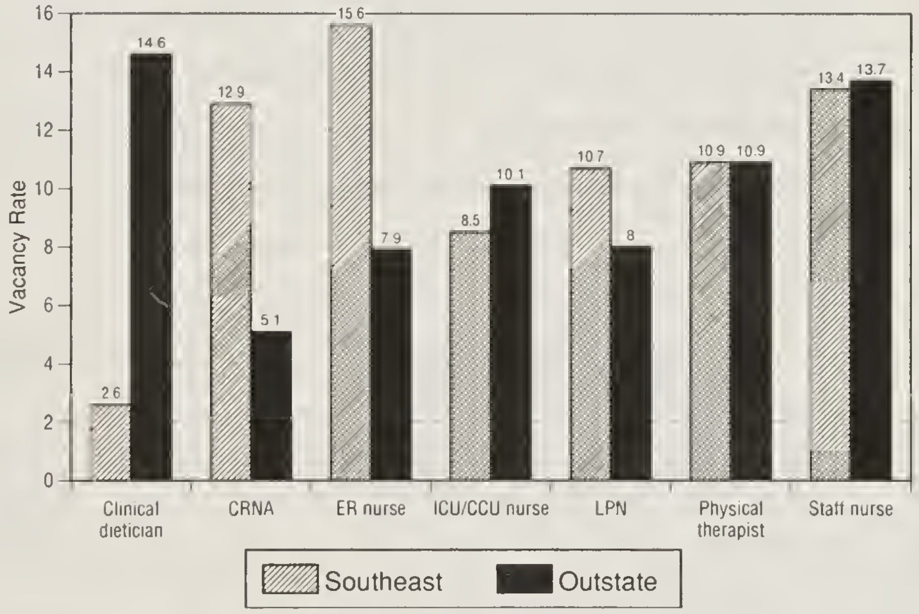
Michigan Vacancy Rates

Staff nurses and emergency room nurses are in shortest supply in Michigan hospitals. Of the budgeted positions, 13.6% of staff nurse positions are vacant and 11.6% of emergency room nurse positions are vacant.



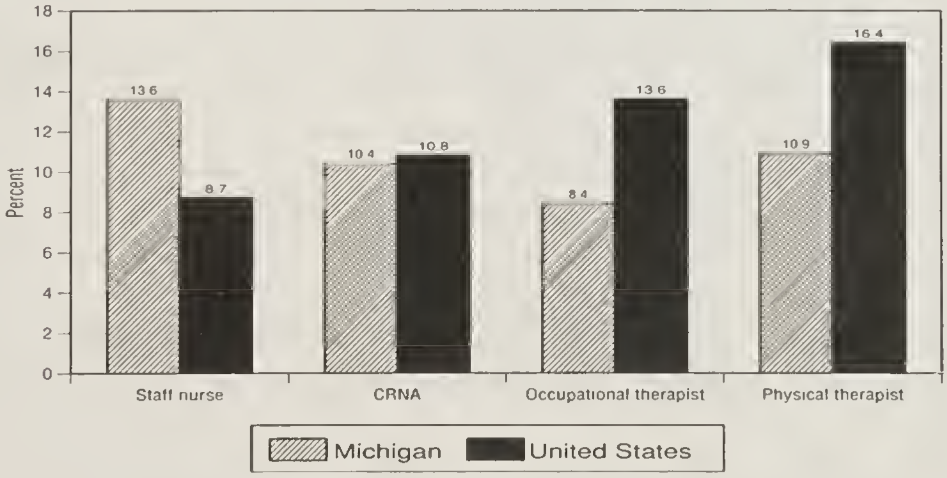
Southeast & Outstate Comparison

The outstate region is most in need of clinical dieticians, with 14.6% of positions unfilled, followed by staff nurses at 13.7%. The southeast region (representing the hospital district area which includes the Detroit and Ann Arbor metropolitan areas) is understaffed by 15.6% for emergency room nurses. Also in short supply in this region are certified registered nurse anesthetists (CRNAs), with a 12.9% vacancy rate.



Michigan & U.S. Comparison

Michigan has a greater shortage of staff nurses than the U.S. and has an equivalent need for CRNAs. The state fares better than the country for occupational and physical therapists, with Michigan having 8.4% and 10.9% vacancy rates respectively.



Coping Strategies Used to Alleviate Shortages

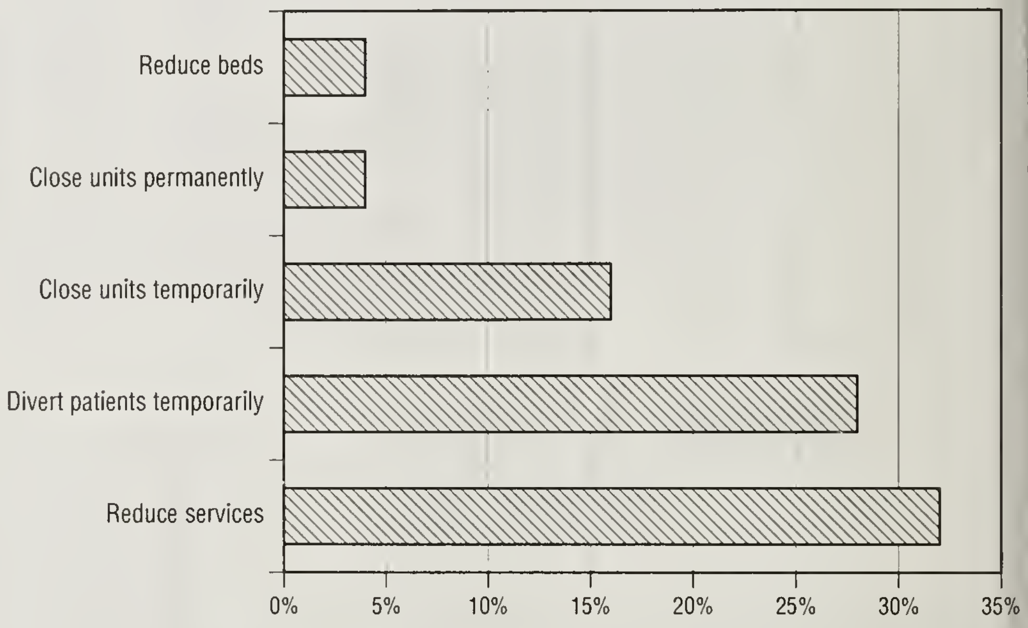
Personnel shortages have forced hospitals to offer incentives to recruit potential employees or to retain existing ones. The most common strategy is to pay more overtime hours. Two alternatives, contracting for personnel with an outside agency or relying on on-call pool staff, provide personnel for ad hoc needs. Innovative scheduling and tuition reimbursement offer regular employees personal opportunities.

Coping Strategies Used to Alleviate Shortages

	Michigan %
Overtime	81
Contract services	70
On-call pool staff	67
Innovative scheduling	64
Tuition reimbursement	62

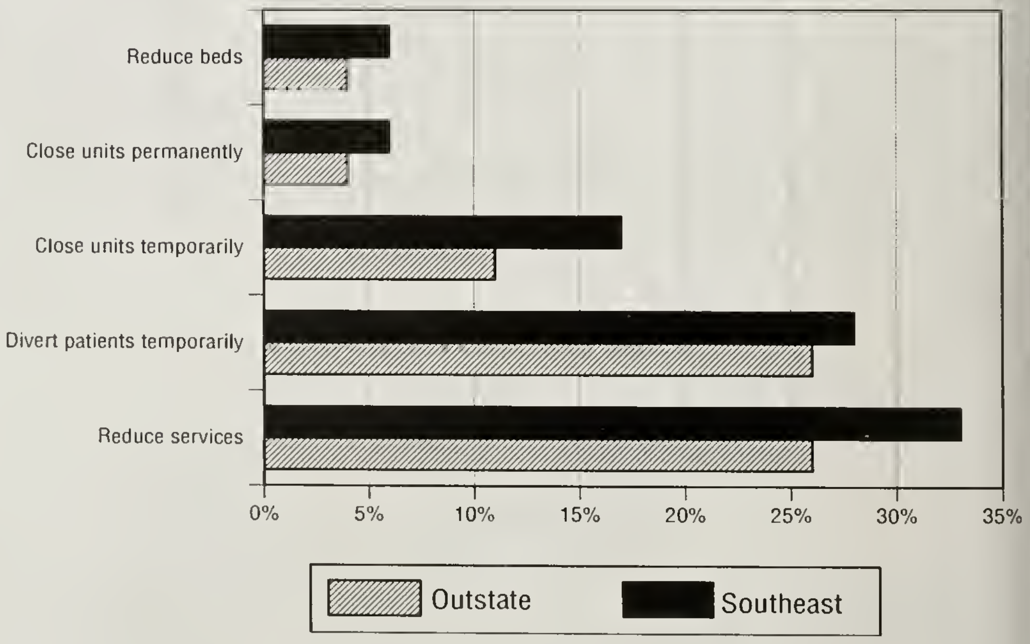
Changes in Hospital Services

In addition to being flexible with personnel, hospitals must also adapt services when shortages occur. Thirty-two percent of hospitals reduce services and 28% divert patients temporarily. Sixteen percent have closed units temporarily, but only 4% have had to permanently close units or reduce beds due to shortages.



Changes in Hospital Services by Region

Both regions reduce services or divert patients most often to adapt to vacancies. Outstate hospitals are more likely to close unites temporarily. Two strategies outstate hospitals have had to employ that southeast hospitals have not are closing units permanently or reducing beds.



SOURCE: Kneisley J, Struthers N, Pietruk, D. Health Personnel Shortage Survey. Michigan Hospital Association Michigan Health Care Institute. Lansing, Michigan. July 1991.

Arbitration key to medical liability reform

By Gerald H. Mandell, MD

MSMS is pleased to publish proposed arbitration limitations in the following article by Randy Watkins, director, Medical Arbitration Program, Michigan Insurance Bureau. (See next page.)

Mr. Watkins provides timely information on hoped-for directions in seeking to resolve the single most significant medical liability problem, namely that of fairness. In all the debate about liability, the one factor most disturbing to physicians and patients is the perceived imbalance in the legal system between truth, justice and monetary awards. Truth is distorted by paid "experts" who are convincing proponents for the plaintiff, physicians often deemed by their peers as prostituting integrity for financial gain. Justice is distorted by lengthy delays in dispute resolution, inordinate profit by attorneys and unconscionable waste within the legal process whereby only 35 percent of settlements may ultimately be received by the injured party. Further, our current judicial system seeks to provide compensation for injury whether caused by the nature of disease, expected complications of diagnosis and treatment, unpredictable adverse events or clearcut malpractice. The open-ended nature of jury awards for pain and suffering are further manifestations of a legal system gone awry.

A somewhat new twist that Mr. Watkin's article brings forth is the ease of offering arbitration in the office. Most of us believe that arbitration for office practice is unneeded because the most serious harm to patients usually occurs in the hospital setting related to invasive procedures. Nevertheless, physicians are exposed to liability by failure to diagnose. Good examples are missing or failing to act on a breast mass that proves to be malignant; failure to perform a PAP smear and follow the results; failure to follow abnormal test reports; failure to diagnose coronary artery disease and failure to specifically address and document patient complaints. Thus, office arbitration should be seriously considered as an option to be offered to our patients.

Finally, arbitration as Mr. Watkins points out, is a cornerstone of liability reform in providing a fair, impartial hearing of facts, allowing appropriate awards for injury, and hastening the litigation process culminating in rapid decisions to benefit both plaintiff and defendant. ☞

Doctor Mandell serves on the Medical Arbitration Panel and is vice-president for medical affairs, Sinai Hospital, Detroit.

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Malpractice Arbitration
A new idea, an old alternative

By Randy A. Watkins, MPA

What do President George Bush, Senator Orrin Hatch (R-Utah), Representative Nancy Johnson (R-Conn) and State Senators Dan DeGrow and John Schwarz have in common? Each has introduced legislation calling for alternative dispute resolution (ADR) for the resolution of professional liability disputes. The key part of their ADR package is an arbitration-like system, something Michigan physicians have had available since 1976.

GAO study conducted

Interest in Michigan's arbitration program led to a request by Rep. Nancy Johnson for a study of the program by the United States General Accounting Office (GAO). The GAO reviewed (1) the extent of hospital, health care provider and patient participation; (2) the arbitration alternatives' effect on medical malpractice claims resolution; and (3) whether arbitration contributed to reducing medical malpractice insurance costs.

The results were predictable. Few hospitals, health care providers and patients have chosen to participate. Due to low participation it was difficult for the GAO to determine the programs's overall effect on the state's medical malpractice claims resolution process. However, for those claims which had gone through the arbitration process and were reviewed by the GAO, arbitration had a positive effect on the timeliness of claims resolution.

A look at the alternatives

The proposals from Washington and Lansing have numerous similarities. They each establish a three-person panel to review the case consisting of a public member or patient advocate, and attorney or retired judge who will act as chair, and a health care provider to provide medical expertise to the panel. Under the current system and in the Lansing proposal, introduced by Senators DeGrow and Schwarz, (Senate Bill 248), potential plaintiffs can voluntarily submit a claim to court or ADR. The Washington proposals would mandate the use of ADR. Moreover, in Rep. Johnson's proposal the use of ADR would be a condition for health care providers and patients participation in medicare.

Senate Bill 248 would establish a voluntary system under the guidance of a nine-member board appointed by the Governor. Five members would represent the public and four would represent health care facilities, physicians, insurers, and attorneys. The board would then appoint three member panels to conduct hearings. The panels decisions would then go to the board for approval. A decision by the board could be appealed to the Michigan Court of Appeals.

Under the current arbitration law, an 18-member advisory committee composed of one-half health care providers, attorneys and insurers and one-half public members, is appointed by the Commissioner of Insurance. You, as a party to a case, have the opportunity to choose who will hear and decide the dispute. The decisions of the panel are final and generally cannot be appealed.

Besides the right to appeal, another difference between the current system and Senate Bill 248, is when the patient/plaintiff enters the system. Under current practice, patients are asked to sign the arbitration agreement at the beginning of treatment; 248 would require that the decision be made after knowledge of an incident has arisen and before filing.

Why get involved?

What's in it for me? To answer that question, let's look at why arbitration was instituted.

1) To reduce the cost of resolving a medical malpractice dispute;

2) To promote equitable settlements and avoid unnecessary appeals;

3) To expedite the resolution of malpractice claims;

4) To provide patients with the freedom of choice by instituting arbitration as a voluntary alternative to litigation.

So, what's in it for you? Staff awareness of the malpractice problem and increased risk management efforts; better communication between the physician's office and the patient (please note that a large number of claims are filed due to the lack of communication); claims are sometimes dropped because of arbitration; and finally, insurers can pursue claims that they might otherwise settle.

Still not convinced? How about *faster resolutions*? Settlement possibilities are enhanced and because of the flexibility within the system, hearing time is reduced. *Less cost.* The GAO discovered that the median defense cost was lower for arbitrated claims than litigated claims. *Justice.* Determinations are based upon facts and evidence. Awards are based upon the needs of the plaintiffs with a lot of the emotional aspects removed.

Arbitrations' advantages are that both you and the patient have an opportunity to present your case before an impartial tribunal with the knowledge that the results are private, final and binding.

What does the future hold?

With the renewed emphasis on alternative dispute resolution, what does the future hold for Michigan's arbitration program? The future appears hopeful.

The GAO recommended that 1) economic incentives be developed to increase consumer interest. This could take the form of health care premiums reductions; and 2) incorporate in health care plans agreements to arbitrate any disputes arising from health care services provided under the plan. These items have been addressed in Senator Nick Smith's arbitration package. Additionally, the Arbitration Advisory Committee is reviewing the program in the light of the GAO report to determine what changes are needed in order to increase participation in the program.

The future is hopeful. With increased physician and hospital participation, it may be possible to make the use of arbitration a meaningful alternative in Michigan.

Randy Watkins is director of the Medical Arbitration Program, Michigan Insurance Bureau.

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1991 Annual
Scientific Meeting

November 12, 13 & 14
Hyatt Regency Dearborn

Spectrum of Medicine in the 90's

CAPSULE SCHEDULE OF ANNUAL SCIENTIFIC MEETING

Monday, November 11

6:00 p.m. Accent Reduction Seminar

Tuesday, November 12

7:30 a.m. Registration/Exhibit Hall Open
8:30 a.m. Office Financial Management Seminar (until noon)
8:30 a.m. Concurrent Scientific Courses (until noon)
  - Basic Cardiac Life Support
  - The Breast Lump: Workup and Treatment
  - Current Psychiatric Concepts: An Update
  - The Medical & Surgical Management of Coronary Occlusive Disease
  - Pulmonary Embolism: Etiology, Diagnosis, and Treatment
  - Reproductive Endocrinology for the Primary Care Physician
  - Rheumatology Update Module
  - Traumatic Brain Injury & Spinal Cord Injury
  - Treatment of Hyperlipidemia
  - Update in Clinical Toxicology

12 Noon Deli Luncheon for All Registrants
1:30 p.m. Concurrent Scientific Courses (until 5:00 p.m.)
  - Bleeding, Clotting and Transfusion
  - Fetal Medicine and Surgery in the 90's
  - HIV Infected Health Care Workers
  - Medical Managment of BPH/Female Urology
  - Osteoporosis
  - Present & Future Issues in Clinical Hypertension
  - Radiology for Clinicians
  - Resurgence of Tuberculosis
  - Sedation and Analgesia for Outpatient & Office Procedures

Wednesday, November 13

7:00 a.m. "Early Bird" Plenary Session: "Substance Abuse: The Physician's

Role." Continental Breakfast Included.
7:30 a.m. Registration/Exhibit Hall Open
8:30 a.m. Concurrent Scientific Courses (until noon)
  - A Closer Look at Substance Abuse and Its Effects
  - Basic Cardiac Life Support
  - Common Ophthalmic Problems Faced by the Practicing Physician
  - Common Surgical Problems in Infants and Children
  - Communicating with the Female Patient Regarding Acute Health Issues
  - Concepts & Controversies in Laparoscopic Surgery
  - Environmental Issues in Primary Care
  - Mastering Common Thyroid Problems: A Case Study Approach
  - The Role of DNA Diagnosis in Clinical Practice

12 Noon Deli Luncheon for All Registrants
12 Noon Women Physicians Luncheon
12 Noon MSMS Committee of Specialty Society Presidents Luncheon
1:30 PM Concurrent Scientific Courses (run until 5:00 p.m.)
  - Allergy and Asthma - 1991
  - Breast and Prostate Cancer
  - Child Abuse Prevention: What Can We Learn From Non-Human Primates
  - Dermatological Therapeutics
  - How to Choose From Alternative Imaging Techniques
  - Physician Services to Nursing Home Residents
  - Psychiatric Issues in the Work Place
  - Update on Inflammatory Bowel Disease

3:00 p.m. Michigan Orthopaedic Society Board Meeting
Reception/Dinner to follow
6:00 p.m. Michigan Occupational Medicine Association
Reception/Dinner
6:00 p.m. Wayne State University Medical Alumni Association Reception

Thursday, November 14

7:00 a.m. "Early Bird" Plenary Session: "Genetics as the Basis for Medicine in the 21st Century." Continental Breakfast Included.
7:30 a.m. Registration Open
8:30 a.m. Concurrent Scientific Courses (until noon)
  - Attention Deficit Hyperactivity Disorder
  - Basic Cardiac Life Support
  - Current Approaches to the Management of the Obese Patient
  - Current Concepts in Blepharoplasty
  - Diagnostic Testing in Back Pain
  - Health Risks to Physicians
  - Interpretation of Arterial Blood Gases
  - Response to Medication in the Elderly
  - The Team Physician

12 Noon Luncheon for All Registrants & Exhibitors
1:30 p.m. Concurrent Scientific Courses (until 5:00 p.m.)
  - Addiction or Affliction: The Relationship of Eating Disorders and Chemical Dependency
  - Adolescent Sexuality Education
  - Biomedical Ethics: Urban Health System Prospective
  - The Clinical Evaluation and Differentiation of the Dementias
  - Management of Lower Extremity Injuries in Sports
  - Management of the Post MI Patient
  - The Resurgence of Childhood Diseases & New Trends in Immunizations: Are Physicians Keeping Pace?
  - Selected Topics in Plastic Surgery
  - Update on Gestational Diabetes Mellitus

6:00 p.m. Michigan Academy of Physical Medicine and Rehabilitation Reception
6:00 p.m. Michigan Academy of Plastic Surgeons Reception
6:00 p.m. Michigan College of Nuclear Medicine Physicians

For further information and a complete conference program, call the Michigan State Medical Society, Office of Physician Education, at (517) 337-1351 or consult the August 20 issue of *Medigram*.

Registration Form

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sday Morning, November 12

a.m. to 12 Noon, Non CME Course)

Office Financial Management Seminar

to Noon, including break)

1 in blank for first choice and 2 for second choice)

- Basic Cardiac Life Support
- The Breast Lump: Workup and Treatment
- Current Psychiatric Concepts: An Update
- The Medical and Surgical Management of Coronary Occlusive Disease
- Pulmonary Embolism: Etiology, Diagnosis and Treatment
- Reproductive Endocrinology for the Primary Care Physician
- Rheumatology Update Module
- Traumatic Brain Injury and Spinal Cord Injury
- Treatment of Hyperlipidemia
- Update in Clinical Toxicology

Wednesday Morning, November 13

(7:15 - 8:15 a.m., No Fee)

_____ "Early Bird" Plenary Session on "Substance Abuse: The Physician's Role" (Continental Breakfast Included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

_____ A Closer Look at Substance Abuse and Its Effects
_____ Basic Cardiac Life Support
_____ Common Ophthalmic Problems Faced by the Practicing Physician
_____ Common Surgical Problems in Infants and Children
_____ Communicating with the Female Patient Regarding Acute Health Issues
_____ Concepts & Controversies in Laparoscopic Surgery
_____ Environmental Issues in Primary Care
_____ Mastering Common Thyroid Problems: A Case Study Approach
_____ The Role of DNA Diagnosis in Clinical Practice

Thursday Morning, November 14

(7:15 - 8:15 a.m., No Fee)

_____ "Early Bird" Plenary Session on "Genetics as the Basis for Medicine in the 21st Century" (Continental Breakfast Included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

_____ Attention Deficit Hyperactivity Disorder
_____ Basic Cardiac Life Support
_____ Current Approaches to the Management of the Obese Patient
_____ Current Concepts in Blepharoplasty
_____ Diagnostic Testing in Back Pain
_____ Health Risks to Physicians
_____ Interpretation of Arterial Blood Gases
_____ Response to Medication in the Elderly
_____ The Team Physician

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day Deli Lunch ☐ **Wednesday Deli Lunch** ☐ **Thursday Lunch** ☐

sday Afternoon, November 12

to 5:00, including break)

e 1 in blank for first choice and 2 for second choice)

- Bleeding, Clotting and Transfusion
- Fetal Medicine and Surgery in the 90's
- HIV Infected Health Care Workers
- Medical Management of BPH/Female Urology
- Osteoporosis
- Present & Future Issues in Clinical Hypertension
- Radiology for Clinicians
- Resurgence of Tuberculosis
- Sedation and Analgesia for Outpatient and Office Procedures

Wednesday Afternoon, November 13

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

_____ Allergy and Asthma - 1991
_____ Breast and Prostate Cancer
_____ Child Abuse Prevention: What Can We Learn From Non Human Primates
_____ Dermatological Therapeutics
_____ How to Choose From Alternative Imaging Techniques
_____ Physician Services to Nursing Home Residents
_____ Psychiatric Issues in the Work Place
_____ Update on Inflammatory Bowel Disease

Thursday Afternoon, November 14

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

_____ Addiction or Affliction: The Relationship of Eating Disorders and Chemical Dependency
_____ Adolescent Sexuality Education
_____ Biomedical Ethics: Urban Health System Prospectives
_____ The Clinical Evaluation and Differentiation of the Dementias
_____ Management of Lower Extremity Injuries in Spo
_____ Management of The Post MI Patient
_____ The Resurgence of Childhood Diseases, and New Trends in Immunizations
_____ Selected Topics in Plastic Surgery
_____ Update on Gestational Diabetes Mellitus

our payment

SMS Members: $50 per course
SMS Members with "retired status": $25 per course
esidents: $25 per course
on-Members: $75 per course
udents: No course fee

IOTE: *Each person attending must pay a 5 one-time registration fee. Includes registration aterials, handouts, refreshments, etc.*

Multiply total number of half-day courses by appropriate fee:

_____ x $50 (members)	= $	_____
_____ x $25 (retired & residents)	= $	_____
_____ x $75 (non-members)	= $	_____
_____ x $12 (lunch tickets)	= $	_____
Adopt-a-Doctor Discount*	- $	_____
One-time Registration Fee	+ $	15.00
TOTAL	= $	_____

ake checks payable to Michigan State Medical Society. Mail to MSMS, Box 950, East Lansing, MI 48826-0950.

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria fo a maximum of 20 credit hours in Category toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed.

nd this entire page with your check. *Confirmation of your reservation will be sent to you.*

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See adjacent page for references and brief summary of prescribing information.

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AXID® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2. Dosage should be reduced in patients with moderate to severe renal insufficiency

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities Age alone may not be an important factor in the disposition of nizatidine Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported Eosinophilia, fever, and nausea related to nizatidine have been reported

Overdosage: Overdoses of Axid have been reported rarely If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774

NZ-2943-B-149347

Additional information available to the profession on request

Lilly

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YOCON®
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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

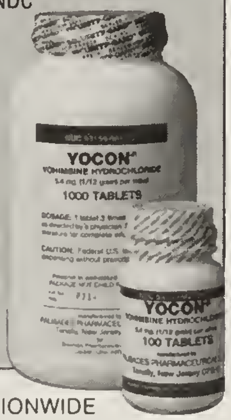
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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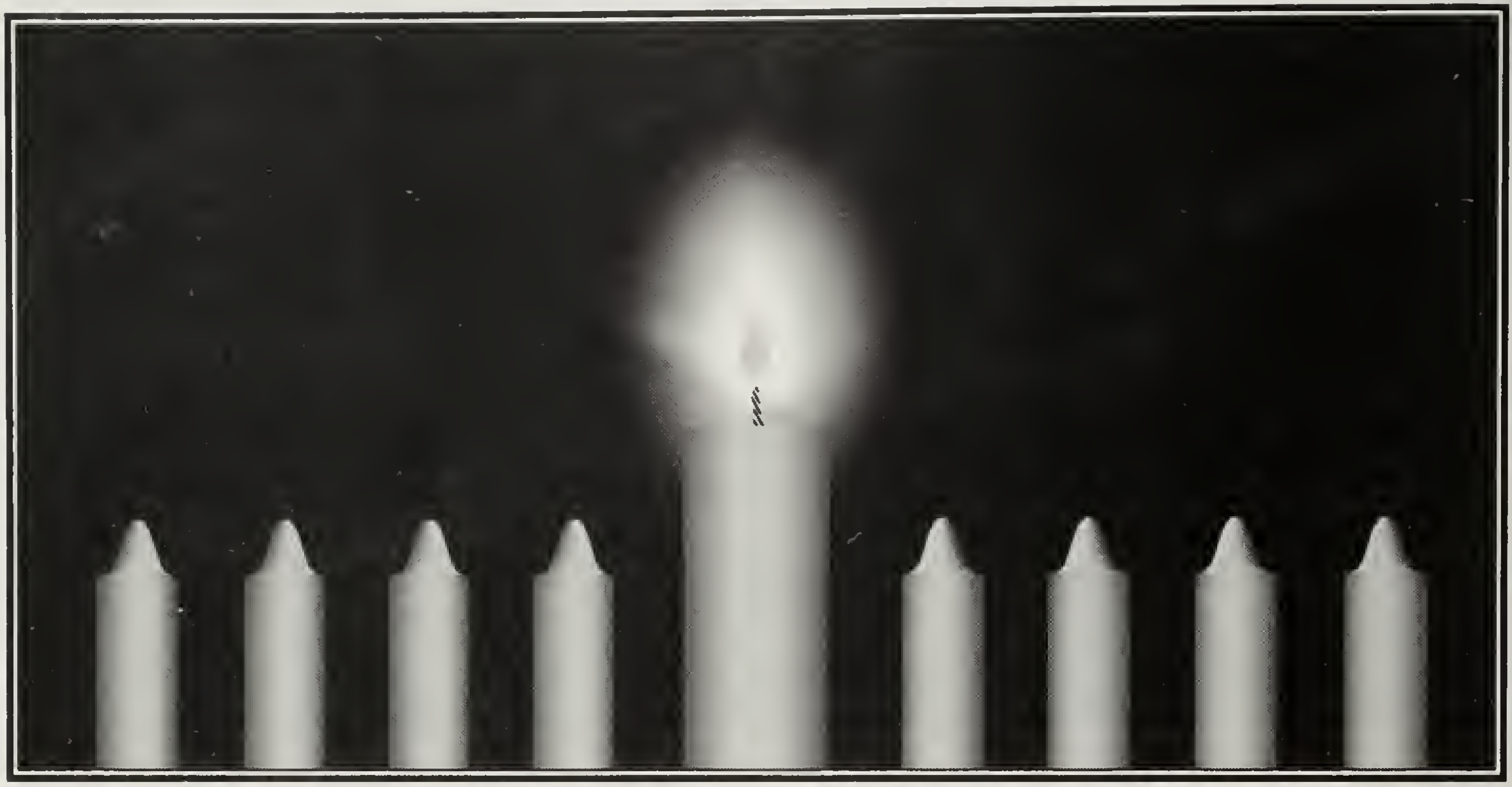

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MEETINGS

MSMS Meetings

September

10, MSMS/MPMLC Current Issues in Risk Management (evening program). Novi Hilton, Novi, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

11, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

11-14, MSMS Practice Management Seminar "Improving Your Practice Productivity And Performance In The 1990's." September 11 at Hyatt Regency, Dearborn, MI; September 12 at University Club, East Lansing, MI; September 13-14 at Grand Rapids Regional Center, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

12, MSMS/MPMLC Current Issues in Risk Management (evening program). Sheraton, Lansing, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

14-15, MSMS Practice Management Seminar "Improving Your Practice Productivity and Performance In The 1990's." Grand Hotel, Mackinac Island. Contact: MSMS Office of Physician Education, (517) 337-1351.

18, MSMS/MPMLC Current Issues in Risk Management (evening program). Port Huron Hospital, Port Huron, MI. Contact: Julie Smith or MSMS Office of Physician Education, (517) 337-1351.

19, MSMS Seminar "Making BCBSM Work For You." Hyatt Regency, Dearborn, MI. Contact: MSMS Medical Economics Department, (517) 337-1351.

21, MSMS Practice Management Seminar "Balancing The Dimensions Of Your Life," a seminar for all physicians, residents, medical students and auxilians, sponsored by the MSMS Committee on Concerns of Women Physicians. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24,25,26, MSMS Practice Management Seminar "Advanced Coding and Reimbursement." September 24 - Holiday Inn, Marquette, MI; September 25 - Grand Traverse Resort, Traverse City, MI; and September 26 - Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

25,26, MSMS Practice Management Seminar "Medical Office Management for the Physician's Spouse." September 25 - Sheraton Oaks, Novi, MI; September 26 - Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Office of Physician Education or Dawn Reha, (517) 337-1351.

October

1,2,3, MSMS Practice Management Seminar "How to Improve Third-Party Reimbursement and Coding." October 1 - Dearborn Inn, Dearborn, MI; October 2 - Bay Valley Inn, Bay City, MI; October 3 - University Club, East Lansing, MI. Con-

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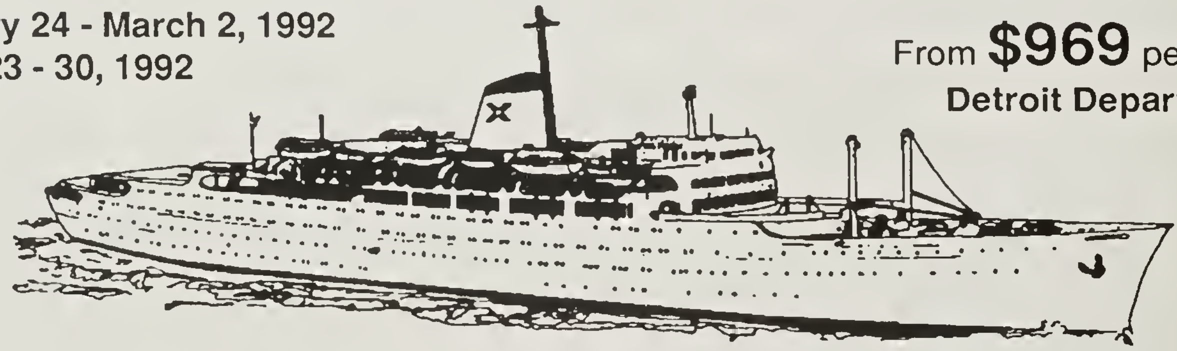

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MEETINGS

tact: MSMS Office of Physician Education, (517) 337-1351.

8,9,10, MSMS Practice Management Seminar "ICD-9CM Diagnosis Coding - How To Do It Right." October 8 - Grand Traverse Resort, Traverse City, MI; October 9 - - Grand Rapids Regional Center, Grand Rapids, MI; October 10 - Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

9, MSMS Seninar "Making BCBSM Work For You." Holiday Inn Crowne Plaza, Grand Rapids, MI. Contact: MSMS Medical Economics Department, (517) 337-1351.

16, MSMS Practice Management Seminar "Retirement Planning." University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

22,23,24, MSMS Practice Management Seminar "1991 BCBS Medicare Update Series." October 22 - University Club, East Lansing, MI; October 23 - Dearborn Inn, Dearborn, MI; October 24 - Bay Valley Inn, Bay City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24, MSMS Practice Management Seminar "Kerr, Russell, and Weber - Health Law Update (1/2 day)." Ann Arbor Regent, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

29, Nov 1, AMA-MSMS Medical Office Staff Training Series. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

November

12-14, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, MI. Over 50 courses offered. Contact the MSMS Office of Physician Education, (517) 337-1351 for a complete meeting program.

AMA Meetings

September

13-15, Rural Health Care, "Strategies to Increase Access." Hyatt Regency, Dearborn, MI. Contact: Department of Registration Services, American Medical Association, 515 N. State St., Chicago, IL 60610, (800) 621-8335.

Michigan Specialty Society Meetings

October

26, The Universal Resistance to Child Analysis, Chicago, IL. Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

November

16, Seventeenth Annual Symposium, "Improving Clinical Skills: Lessons from Longer Psychoanalytic Treatments." Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

October

10-13, American Society of Internal Medicine 35th Annual Meeting. Contact: Lisa Derby, (202) 289-1700 ext. 615.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

September

10-17, Psychiatric Nomenclature-Jargon or Tool. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 3000 Town Center, Suite 1250, Southfield, MI 48075, (313) 353-0050. **Approved for:** 4 hours Category I Credit.

11-12, Office Procedures for Primary Care Physicians. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jones, Registrar, Postgraduate Medicine, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800 or (800) 962-3555. **Approved for:** 16 hours Category I Credit.

13-14, Post-Operative Pain Management Symposium & Workshops. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jones Registrar, Office of Continuing Medical Education, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 11 hours Category I Credit.

14, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw, Michigan. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 6 hours Category I Credit.

16-17, Child Abuse and Neglect. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Hospitals Child Protection Team, Michigan Committee for the Prevention of Child Abuse and Michigan Department of Social Services. **Contact:** Julie Jones, Registrar, Office of Continuing Medical Education, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

23-24, Critical Clinical Issues In The Care of The Elderly: Evaluation and Treatment of Depression. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Veterans Affairs Medical Center and Department of Veterans Affairs Cleveland Regional Medical Education Center. **Contact:** Julie Jones,

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CATEGORY I COURSES

Registrar, Office of Continuing Medical Education, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 11 hours Category I Credit.

27-28, Urology Update – 1991. Location: Ritz-Carlton, Dearborn, Michigan. **Sponsor:** William Beaumont Hospital, Department of Urology. **Contact:** Department of Urology Conference, Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073, (313) 551-0803. **Approved for:** 14 hours Category I Credit.

30-10/1, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. **Contact:** Julie Jones, Office of Continuing Medical Education, G1100 Towsley Center, P. O. Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 14 hours Category I Credit.

October

17-19, Modern Perinatal Problems. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jones, Registrar, Office of Continuing Medical Education, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 16 hours Category I Credit.

20-21, Fiberoptics Workshops for the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jones, Registrar, Office of Continuing Medical Education, P. O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 15 hours Category I Credit.

25-26, Advanced Cardiac Life Support Instructors Course. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsors:** Michigan Chapter of the American College of Emergency Physicians and American Heart Association of Michigan. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 16 hours Category I Credit.

November

14-15, Advanced Pediatric Life Support Course. Location: Children's Hospital, Detroit, Michigan. **Sponsors:** American Academy of Pediatrics and Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

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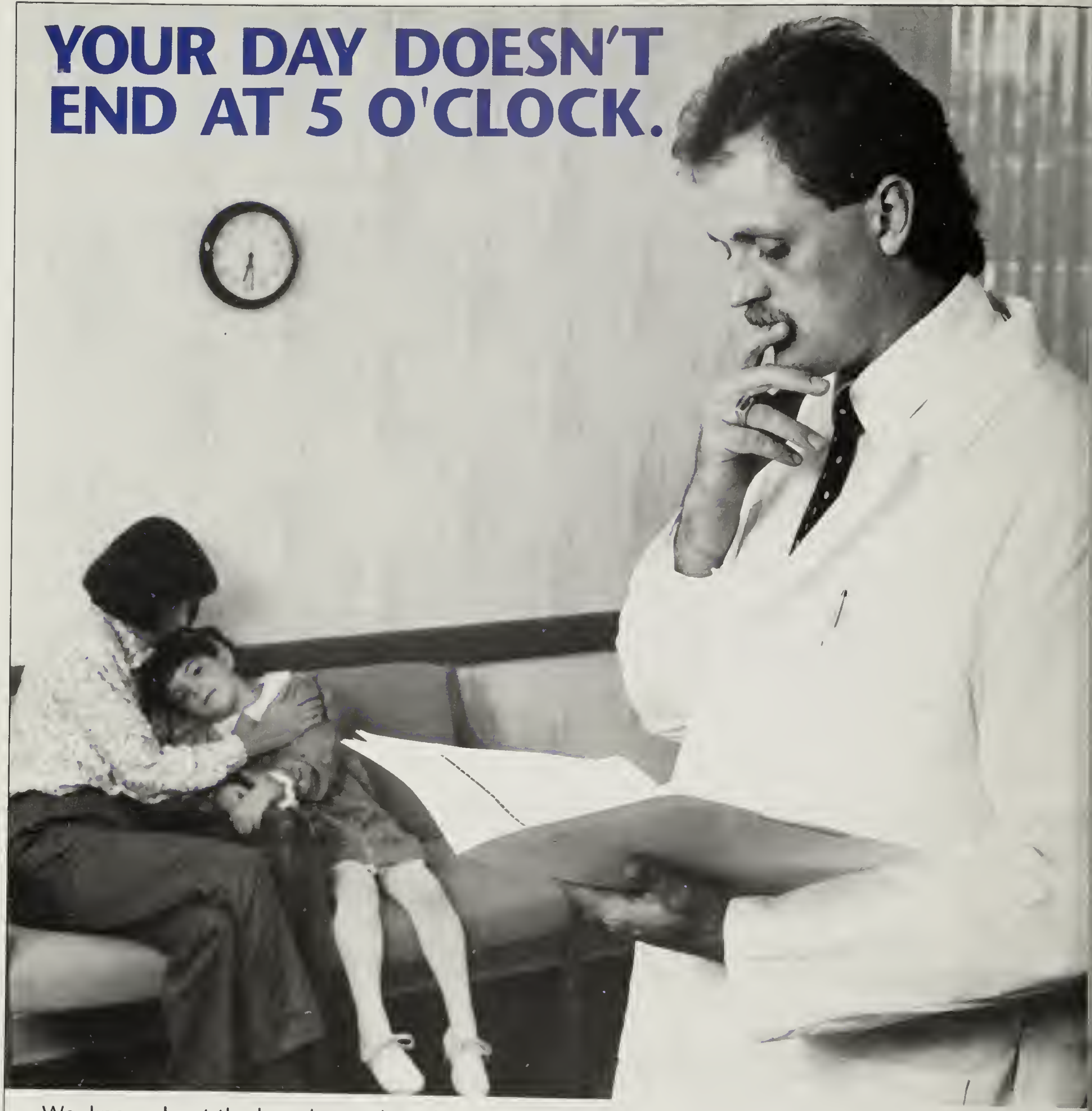

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Medicine and the Arts
There has always been a strong connection

By Robert D. Burton, MD

"Music has charms to soothe a savage beast"
— William Congreve, 1697

Serendipitously, the month during which this was being written, the US Senate was being lobbied by an unlikely coalition of MDs, PhDs, rock and rollers and senior citizens, all testifying that music is an integral part of mental and physical therapy. And locally, Governor John Engler, who has been much maligned for his cuts in public funding for the arts, was talking about ways to keep the arts available to the public.

Now more than ever, it seems the arts are becoming recognized as an important part of everyday life. We need the arts to sustain us, to motivate us, to give us hope and to distinguish us as beings able to perceive and project beyond our selves.

To most physicians reading this, however, this new-found appreciation for the arts is likely nothing new. A strong connection, almost a bond, has always existed between medicine and the arts.

The connection may begin with sensitivity. Physicians share with the painter, the sculptor, the musician, a sensitivity of perception. We all must perceive, be open, be alert beyond simple consciousness to a higher level that allows us to see, to understand, to empathize and then translate those feelings and cognitions into action. An artist, like the physician, takes the ordinary, and through his perceptions and skills, transforms it into something meaningful.

Physical skills and dexterity also link the artist and physician. The most obvious and common comparison is the surgeon and the sculptor, both relying on skilled eye-hand coordination to produce works of art.

The rhythms of the human body and the rhythms in music also have a strong connection. When any one of the human body's instruments is not in tune or not keeping the beat, the whole internal orchestra can lose its syncopation, its rhythm.

"Rhythm is at the very center of our lives," said the drummer for a venerable rock and roll band, the Grateful Dead. He thinks longer life can be achieved by older people sitting in circles and pounding on drums.

But music is good not only for the aged. An expert in childhood music at the University of Rochester's School of Music said recently at a workshop in Grand Rapids that the value of music can begin to be instilled in an infant simply through the songs parents sing to quiet them.

A final observation on the common thread between medicine and the arts. If George Lundberg, MD, editor of the *Journal of the American Medical Association* (JAMA), can find a famous, medically related piece of art to grace the cover of each week's JAMA, then who are we to deny that there is an inextricable link between medicine and the arts?

Doctor Burton is MSMS president.

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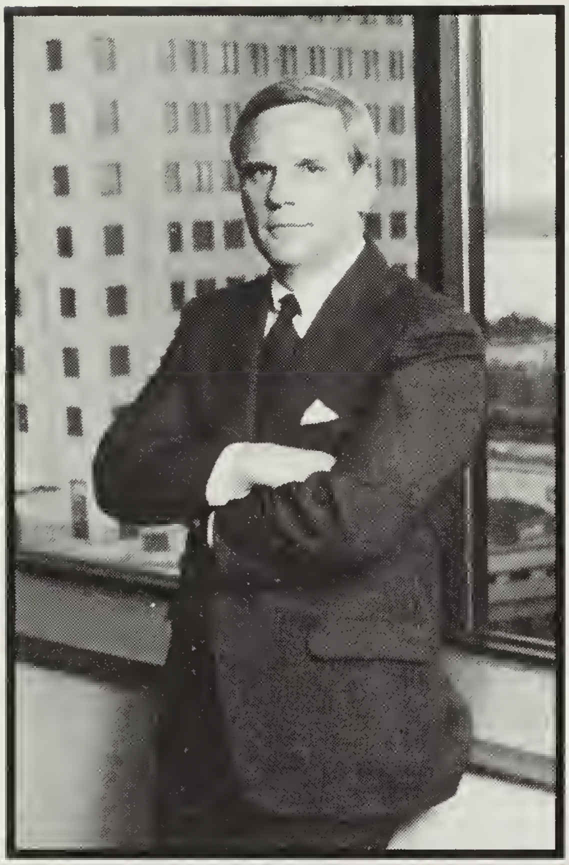

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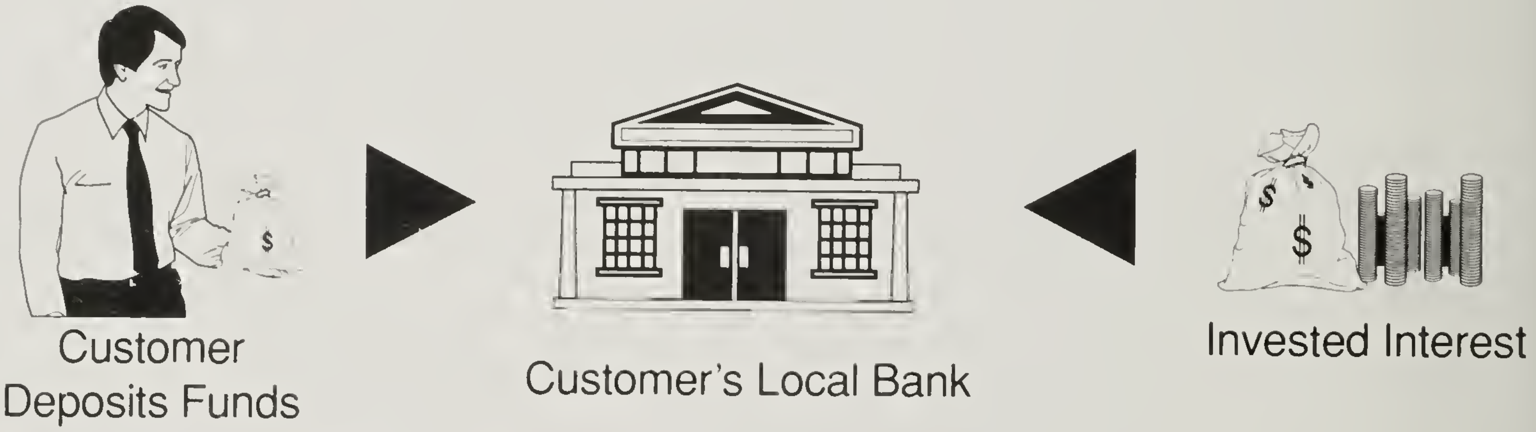

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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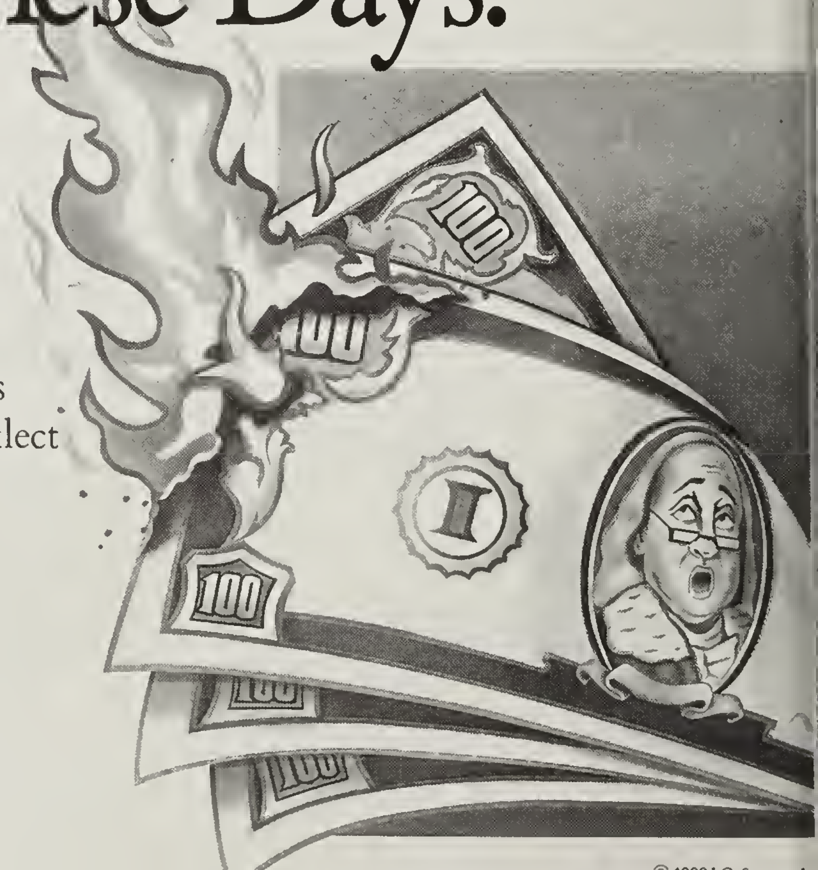

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MICHIGAN MEDICINE

OCTOBER 1991 VOLUME 90, NO 10

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

"Spectrum of Medicine in the 90s" is the theme of this year's Annual Scientific Meeting, scheduled for November 12-14 at the Hyatt Regency Dearborn. The meeting will offer more than 50 half-day courses on timely medical issues which cut across all specialties. Continuing its efforts to help make the ASM the best it can be, this month's *Michigan Medicine* features an in-depth, 32-page program. You may pull it out and take it with you to the meeting or save it for handy reference. Either way, we hope you find this program worthwhile. Preceding the program is a short article on the history of the meeting. This informative article begins on page 26. Program details appear below.

PROGRAM HIGHLIGHTS

"Early Bird" Plenary Sessions

This year's Annual Scientific Meeting will offer two "early bird" plenary sessions. The first will feature Charles Vincent, MD, chief of the Department of Gynecology, Hutzel Hospital, who will discuss "Substance Abuse: The Physician's Role." The second session will feature Francis Collins, MD, professor of Genetics and Internal Medicine, University of Michigan Medical School, who will discuss "Genetics as the Basis for Medicine."

Scientific Courses

More than 50 half-day courses offering practical and clinical information will be held during the three-day event.

Exhibits

Approximately 77 exhibitors will be on hand at the Annual Scientific Meeting to meet with attendees.

Special Events

A variety of special events have been planned for this year's Annual Scientific Meeting. Among them is an accent reduction seminar for international medical graduates. Also planned is a seminar on office financial management. Physicians' office staff are encouraged to attend.

DEPARTMENTS

9 LETTERS
13 MSMS ON THE MOVE
19 PHYSICIANS IN THE NEWS
33 OBITUARIES
41 MEETINGS
45 CATEGORY I COURSES
51 CLASSIFIEDS
53 ADVERTISING INDEX
56 PRESIDENT'S PAGE

In next month's issue:
MSMS membership

Cover illustration: *By Robert L. Brent*

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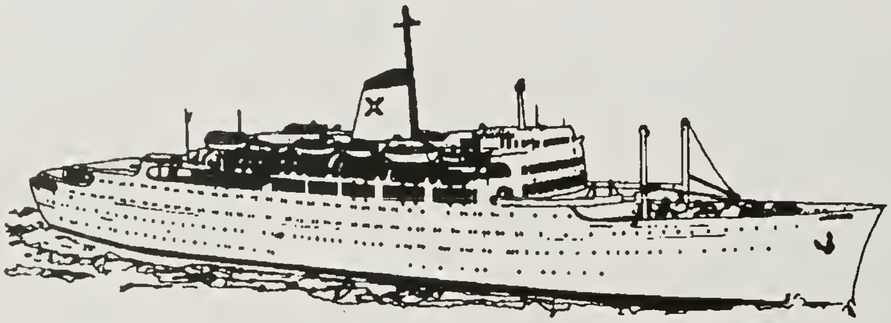

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LETTERS

Editor's Note: Following is a letter sent recently to Susan H. Adelman, MD, *chairman of the* MSMS Liaison Committee *with* Blue Cross *and* Blue Shield *of* Michigan, *regarding the relationship of* MSMS *with* BCBSM. *Immediately following the letter is her response. Both letters are reprinted here for the benefit of* Michigan Medicine *readers.*

MSMS should adopt a more adversarial relationship with the Blues

Dear Doctor Adelman:

I wrote to you earlier this year about Blue Cross Blue Shield of Michigan. At the time, I did not feel that it was proper for the Medical Society to allow BCBSM to have participation seminars under MSMS auspices. You may recall that you answered my letter.

August 5, 1991, Judge Robert Borsos reversed the determination of former Insurance Commissioner Shah concerning Medical Doctor Class Plans. You should read the findings. Although I had nothing to do with them, the litany of problems Judge Borsos writes about sound like they came from me.

Instead of coming from me, however, they come from responsible and concerned physicians around the state.

I think it is time for MSMS to consider these concerns, and to adopt a more adversary position with BCBSM. Our hands are not tied, and although it may be less comfortable for our elected representatives to go head-to-head with BCBSM (and perhaps litigate key issues), it is perhaps time to consider such action.

I imagine Richard D. Weber (MSMS legal counsel) has received a copy of Judge Borsos' determination by now. At the least, I think it would be appropriate to publish his comments concerning the determination in *Medigram*.

Furthermore, as you read Judge Borsos' opinion, you may become convinced that the members of the Medical Society are not all supportive of a close relationship with BCBSM as it presently behaves.

I would like to suggest that the membership be surveyed to see how strongly they feel about BCBSM, and if I am correct, that MSMS adopt a less conciliatory position.

I am not suggesting that we negotiate fees as a group. I am aware that this has antitrust implications. However, BCBSM is a large organization with much money behind it, and each member of MSMS is an individual. We should be able to identify the more outrageous aspects of BCBSM's behavior, and if the Insurance Commissioner is not willing to remedy them, we should be able to litigate.

David L. Joseph, MD
405 W. *Greenlawn* #125
Lansing, MI

MSMS is working with the Blues in a cost-effective, timely manner

Dear Doctor Joseph:

After spending countless hours over the last several years of my life in a highly adversarial relationship with Blue Cross Blue Shield of Michigan, I find that your letter of August 16 reflects no sense of what either I or the Michigan State Medical Society have done for our members. MSMS has monitored the hearings before Judge Borsos, consulted with the attorneys involved on a regular basis, read and purchased the depositions, and read, distributed and studied the recent decision. We are now engaged in a series of individual and group discussions with the attorneys who represented the appellants before Judge Borsos, with MSMS legal counsel, staff and leadership.

MSMS has been the principal party to collect the concerns and complaints of physicians against BCBSM, as well as to engage in a protracted and complex negotiation, trying to resolve as many of these as possible, with instructions to report back to Senator Posthumus and the four other legislators who have expressed their personal concern. There are at least 44 different areas in which we have tried to achieve progress, several of which have improved markedly since we started.

We worked relentlessly on objectionable provisions in the physician contract for over a year, then for another year in the Physician Contract Advisory Committee. We have achieved whatever we could without a lawsuit, and now we will have the opportunity to make even greater progress since the recent decision by Judge Borsos. The issues raised in the suit will come directly before the PCAC, as well as the MSMS-BCBSM Liaison Committee, with the intent of resolving as many as possible. Obviously actual financial negotiations per se are impossible because of the antitrust laws, though we can advise that there are areas in which fee adjustments might improve access.

The reasons why we have used the committee format instead of bringing multiple lawsuits against BCBSM are two: cost and time. Our members strongly object to dues increases. If we sue, the Blues will drag out the proceedings in order to exhaust our time and money. You

Continued on page 11

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Continued from page 9

will see that this suit, while successful in "round one," will be appealed. Then it will take time to get from the issue of the Provider Class Plan to the contract. If we had gone that route in the first place, you still would not have received your nine percent increase, such as it was.

Meanwhile, we are taking up the specific issues discussed in the lawsuit through the PCAC. We may finish off these issues before the legal process ever addresses them, and if so, we shall do so far more cheaply.

We find that our members may call for lawsuits, but they object violently to paying increased dues. We try to do our best within our limits. If others wish to sue over specific issues, we can be supportive, as we were in the recent appeal.

As far as your enclosed correspondence to Doctor Beardon, the issue of "per service" vs per case participation was not addressed in the BCBSM Provider Class Plan, therefore it will not be affected by the recent appeal before Judge Borsos. In fact, this was forced on BCBSM against their will by the legislature in PA 350. Relief requires new legislation to amend that act, and MSMS has been looking actively at sponsorship of such a bill. Our fear though is that this provision was the compromise with forces favoring mandatory participation.

Since mandatory participation in Medicare just lost by a whisker in the Michigan legislature, I fear that an attempt to legislatively eliminate "per service" participation will yield mandatory participation in BCBSM for all, quite the opposite of our intent.

If you have further questions, please do not hesitate to contact me again, or you may contact Mary Anne Ford at MSMS. ■

Susan Hershberg Adelman, MD
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MSMS *ON THE MOVE*

A monthly update of key MSMS activities

Focused opposition on proposed rules forces HCFA review

Physician unity and political organization on fair reimbursement, combined with the lobbying efforts of the AMA, MSMS, and other state and county medical societies, has caused the Health Care Financing Administration (HCFA) to sit up and take notice. HCFA last June proposed rules on the implementation of the new resource-based relative value scale (RBRVS) Medicare reimbursement system scheduled to take effect Jan. 1, 1992. The proposed rules would result in a 16 percent cut in the conversion factor that changes relative value units for physicians' work into Medicare dollars. The proposal elicited 95,000 responses from around the country by HCFA's Aug. 5 deadline.

MSMS sent a delegation led by Board Chairman Jack L. Barry, MD, and President Robert D. Burton, MD, to Washington during the summer to lobby Congressional representatives to put pressure on HCFA to rescind the conversion factor cuts. The delegation met successfully with congressmen, senators and a number of other government officials. These meetings and similar meetings by other state delegations have resulted in correspondence on the issue from 420 members of Congress to HCFA, the Department of Health and Human Services, the Office of Management and Budget and President Bush. The correspondence included a letter from the Michigan Congressional delegation to Department of Health and Human Services Director Louis W. Sullivan, MD, outlining serious concern about HCFA's proposed rules. Because of the resounding opposition, HCFA is now discussing revisions to its proposed rules.

MSMS/AMA tell the story of how physicians care

MSMS is the first state medical society to join the AMA in a new communications campaign to show the American public that physicians are caring and concerned about their well-being. The campaign is called MD 2000, and began in August with ads in *Time*, *Newsweek*, and *U.S. News and World Report* profiling the work of four physicians and how they care for their patients. MSMS plans to run the same ads in *Michigan Medicine* in the next few months. The campaign is intended not only to strengthen the bond between physicians and their patients, but also to strengthen the ties between physicians and organized medicine. To that end, both MSMS and the AMA are encouraging physicians to become members of organized medicine. MSMS currently is reviewing several ways to do that on the state level. Contact Deborah Zannoth at MSMS for further information.

For details call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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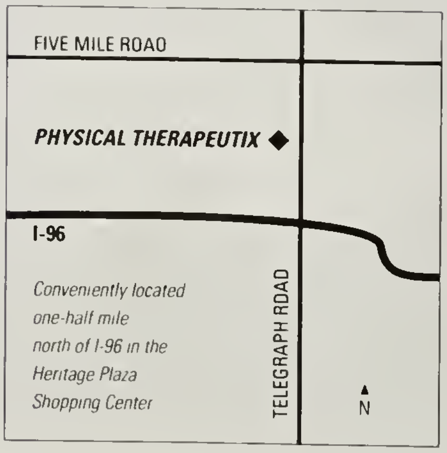

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[2] Standard industry new prescription audit

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Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

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Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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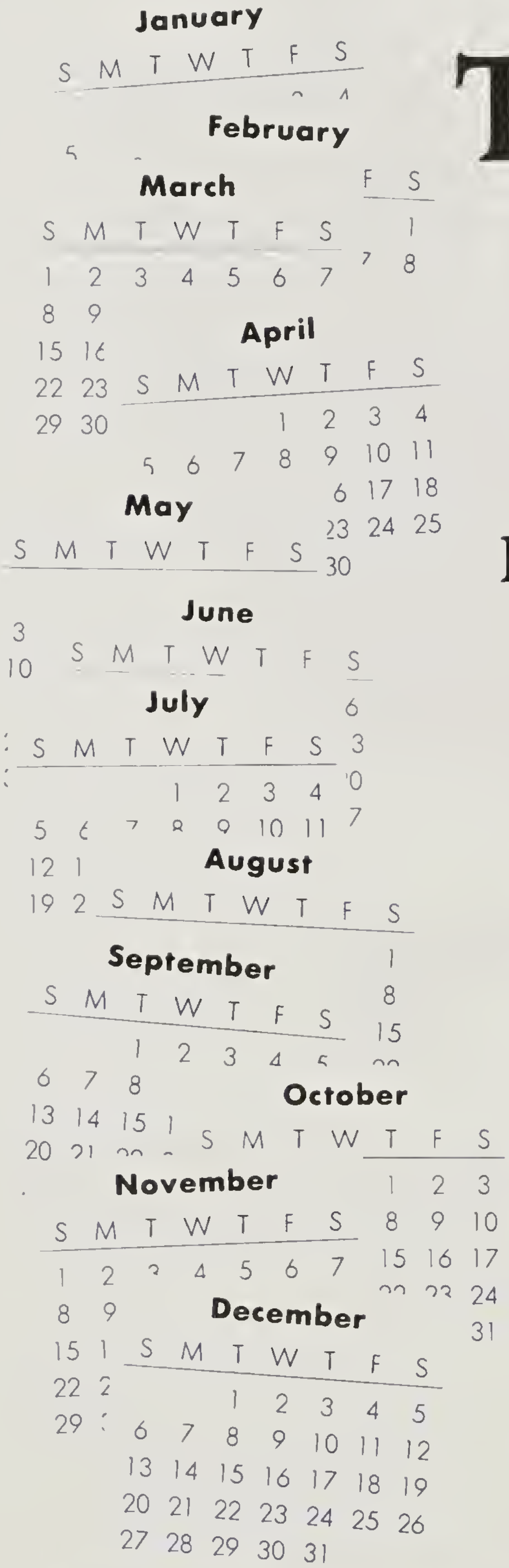
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PHYSICIANS IN THE NEWS

John Battle, MD
director of the Oakwood Hospital Family Practice Residency Program, and Medical Education director, recently was inducted as president of the Michigan Academy of Family Physicians. Doctor Battle also serves on staff at Wayne State University School of Medicine as a clinical professor.

John J. Collins, Jr., MD
is the newly appointed executive vice president of Henry Ford Mercy *Health Network*. He was the former vice president of Professional and Physician Services for MHS. The Network is a joint venture between Mercy Health Services (MHS) and HFHS. Their focused attention is developing relationships with physicians for quality affordable health care in Wayne County and for comprehensive health services in Oakland and Macomb counties. Those participating in the plan include: Samaritan Health Center and Mercy Family Care Centers, Detroit; and St. Joseph's Mercy Hospitals and Health Services, Macomb County.

Michael M. Kaplan, MD
a Southfield specialist in thyroid disease, was recently appointed to a national advisory panel of experts in the field of endo-crinology by the United States Pharmacopeial Convention, Inc. (USP). USP sets legally enforceable standards with drugs in the United States and publishes information for health professionals and patients about the use of medicine. It is a nonprofit organization composed of representatives from universities, industry, government, and local associations.

Bruce Steinhauer, MD
senior vice president of Medical Affairs *for* Henry Ford *Health Systems* and former chairman of the Henry Ford Medical Group Board of Governors, has accepted the appointment as president and chief executive officer of the Lahey Clinic, Boston.

Sita Ram Kaura, MD
a Lincoln Park emergency medicine physician, serving on staff of Wyandotte Hospital and Medical Center, authored after eight years of research, a book titled "A Family Doctor's Guide to Understanding and Preventing Cancer: Environmental Risks and Solutions." The reference book is geared for health care professionals and the general public as well. The publication supplies strategies for detecting and treating cancer.

Donald E. Greydanus, MD
pediatrics program director for Michigan State *University Center for Medical Studies* and local pediatrician, is editor-in-chief of a new book released in September by the American Academy of Pediatrics. The book, *Caring for Your Adolescent*, is a total reference guide for parenting children from ages 12 to 21. Detailed information is provided addressing a broad range of medical and parenting concerns. The book will be available in book stores nationwide.

Robert Macdonald, MD, PhD
professor of neurology and physiology at the U-M *Medical Center*, has been selected to serve as a member of the Neurological Sciences-2 Study Section, Division of Research Grants for the Department of Health and Human Services of the National Institutes of Health. Study sections review grant applications submitted to the NIH, make recommendations on these applications to the appropriate NIH national advisory council or board, and survey the status of research in their fields of science.

Maurice Reizen, MD
former state health director, is the recipient of one of the first two awards from the University of Michigan's Public Health Alumni Society. "I've gotten lots of awards, but this one really thrills me," he recently told a reporter from the *Lansing State Journal*. "Having recognition of your peers is really meaningful."

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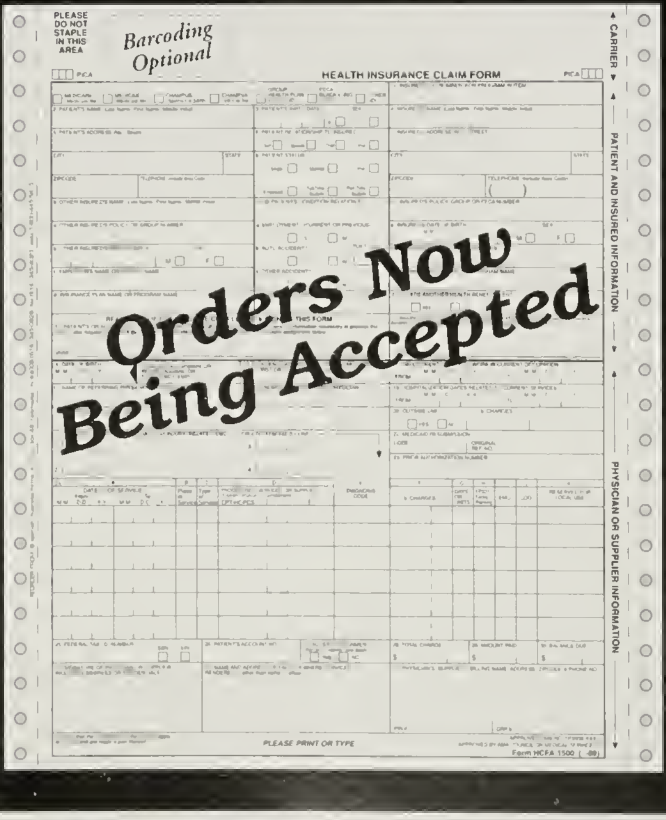
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REMARKS: ____

A LOOK BACK at the HISTORY of the MSMS ANNUAL SCIENTIFIC MEETING

By Herbert A. Auer

Question:

If the 1976 Annual Scientific Meeting awarded 11,168 hours of Category I CME Credit, how many hours would you guess the 1990 Scientific meeting awarded at a time now when the Category I Credit field is supersaturated?

Answer:

While many state medical societies report decreasing participation at annual scientific meetings, the MSMS meeting last year provided "more than 11,000 hours of Category I Credit."

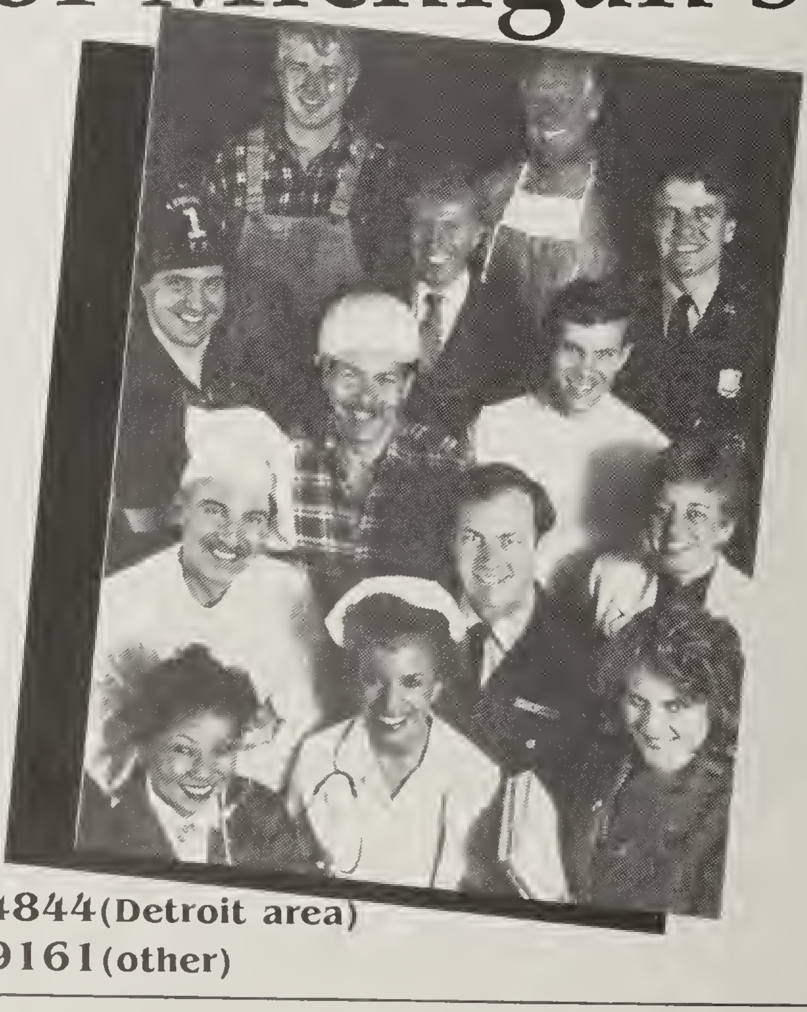
"The fact that MSMS offered many quality Category I courses to attract virtually the same participation last year is amazing," declares Sherry Fent, MSMS manager of Administration and Physician Education. She remembers well when in 1976 MSMS changed its entire approach to the Annual Scientific Meeting to the more successful present series of half-day morning and half-day afternoon courses.

"Back in 1976, the pressure was on Michigan physicians to earn the necessary hours to have their licenses recertified after the state made continuing medical education mandatory. The 1976 fall meeting was virtually the only big Category I Credit game in town."

That first "new" scientific meeting in 1976 saw total course registrations reach 4,908 with most doctors registering for one, two, or three courses.

Most of the course directors — as is true today — wrote course outlines, and effectively utilized pre and post tests, case studies and bibliographies. Many state medical specialty societies served as course sponsors.

Michigan Medicine, wrote about the 1978 meeting like this: "Can you imagine the detailed planning required for MSMS to offer 12 half-day courses with 549 registered physicians in the morning and then 13 different half-day afternoon courses for 756 doctors. All of this went smoothly while getting more than 100 professors and distinguished practicing physicians into the right room at the right time to teach the right course."



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Past v. present

Prior to 1976, the MSMS fall meetings, in effect, usually seated all the registrants in the same big room. "The physicians sat through 20-minute lectures by unrelated speakers about unrelated subjects with one following the next in rapid succession," Doctor Wiegenstein told the MSMS Council. That was the common practice then across the nation.

Many older MSMS members remember the years when the House of Delegates met in September on Sunday night and all day Monday and Tuesday followed by the Scientific Meeting all day Wednesday, Thursday and Friday morning.

For many years, the single Michigan physician who challenged and assisted MSMS to deliver postgraduate lectures and clinics across the state each spring and fall was Harry A. Towsley, MD, Ann Arbor. Doctor Towsley served many years as the chairperson of the MSMS Committee on Postgraduate Medical Education from his base as chairman of the U-M Medical School Department of Postgraduate Education.

A review of the 1968 Spring brochure, listing 18 programs, was typical of those years. Programs were provided by MSMS in the Upper Peninsula and also in Alpena, Battle Creek, Cadillac, Grayling, Lansing, Midland, Muskegon, Niles, Petoskey and Port Huron. A clinic program at the local hospital was conducted by the guest professor in the afternoon followed by dinner and a medical lecture, usually at the county medical society meeting.

In the Upper Peninsula, two physician presenters started at Ironwood on the far West and traveled East through Houghton and Iron Mountain and on to Marquette. Two other professors began at Sault Ste. Marie and stopped at Manistique, Escanaba and Menominee before also going to Marquette. There the four professors would spend a full afternoon at a hospital clinic and share the program that evening.

Distinguished professors with the WSU and U-M medical schools and experts from the Department of Public Health cooperated in this much-appreciated series.

MSMS also provided many continuing education opportunities during that era at an annual Michigan Clinical Institute, always held in Detroit.

Throughout its 125 year history, MSMS has played — and continues to play — a major role in the education of physicians and allied health professionals. ■

Herb Auer was deputy director of MSMS before becoming executive director of the Michigan Health Council in 1979.

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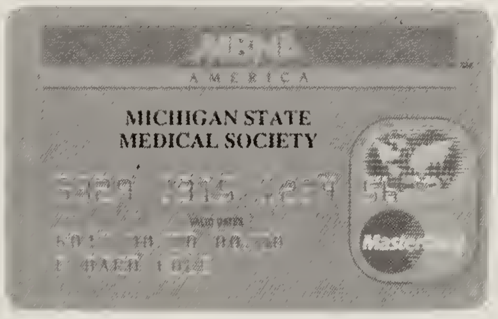

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Michigan State Medical Society
1991 ANNUAL SCIENTIFIC MEETING
November 12, 13 & 14
Hyatt Regency Dearborn

Welcome to the Meeting......

1991 MSMS Annual Scientific Meeting, November 12, 13 & 14, Hyatt Regency Dearborn

Welcome to the 126th Annual Scientific Meeting of the Michigan State Medical Society.

The following pages present detailed information regarding the Category I CME courses and special events t are a part of the MSMS Annual Scientific Meeting. They will serve as the conference final program, and will be inclu in the October issue of Michigan Medicine in order to provide this information to a wider audience.

If you haven't already registered for the conference, take a few minutes to review the course descriptions and p now to attend. We thank the many medical specialty societies, MSMS sections, hospitals, and medical sch departments for their efforts and cooperation in planning this comprehensive CME project.

We thank you for participating in this Scientific Meeting and we welcome your comments on how to furt improve the meeting in future years.

Planning Committee for MSMS Annual Scientific Meeting

PLANNED BY YOUR PEERS... The Planning Committee for the 1991 MSMS Annual Scientific Meeting is made up of dedicated volunteers from many specialties, practice settings and geographic locations. They have planned the details of this year's meeting with this one purpose in mind: To provide a high standard of educati opportunities, at a reasonable cost, for Michigan physicians. quality of programming at this years Scientific Meeting reflects t commitment to that purpose.

Conrad E. Nagle, MD, Troy, *Chairman*
Rudi Ansbacher, MD, Ann Arbor
Stephen D. Barbour, MD, Ada
Deloris A. Berrien-Jones, MD, Taylor
Frederick W. Bryant, MD, Troy
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John O'Donnell, MD, Grand Rapids
Butchie B. Paidipaty, MD, Livonia
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Joan C. Stryker, MD, Detroit
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  Chairman, MSMS Committee fo
  CME Programming
Jack L. Barry, MD, *Chairman*
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  MSMS President

Life Support Station

The MSMS Annual Scientific Meeting, in cooperation with the Michigan College of Emergency Physicians, is prepared to handle medical emergencies of all its participants that may occur within the physical confines of the Hyatt Regency Dearborn. A Life Support Station is staffed Tuesday through Thursday during the hours of the meeting by emergency medicine residents from area hospitals and by nurses and/or paramedics from the Lansing area.

IN CASE OF EMERGENCY... In the Hyatt Regency Dearborn, **CALL 1280,** Tuesday or Wednesday, November 12 & 13, from 8:00 a.m. to 6:00 p.m., and on Thursday, November 14 from 8:00 a.m. to 5:30 p.m. or go to the Life Support Station adjacent to the pool on the first level. AT ALL OTHER TIMES CALL 2222 AND STATE THE EMERGENCY. Please read carefully the following:

1. If an emergency (e.g., cardiac arrest) occurs during the hours the Station is open, proceed to the nearest telephone and **call 1280.** State the floor, area and room the patient is in and the nature of the problem as well as the number of the phone from which you are calling.

2. When the Life Support team arrives, they will assume comm of the emergency care. Do not interfere or offer assistance un asked to do so. Assist with crowd control and open a passage for evacuation of the patient.

3. Do NOT summon an ambulance or call the hospital as this be done by the team.

4. Persons needing medical attention may come directly to the Support Station.

5. Robert K. Orr, Jr., DO, is the director of the Life Support Stat Inquiries concerning Life Support Station operation shoul directed to him.

MSMS Thanks the following for contribution of equipment supplies to the Life Support Station:

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This Booklet...

neral Information 3
psule Schedule 4
urse Details:
Tuesday, November 12 6
Wednesday, November 13 11
Thursday, November 14 17
hibit Center Floor Plan 23
Exhibit Descriptions 24
Index to Exhibitors 27
Special Events 28
Index to Instructors 29
Index to Cooperating Groups 30
Registration Form 31
Hyatt Regency Floor Plan 32

eneral Information...

GISTRATION: The registration desks will be located in the at Lakes Exhibit Center, First Floor, Hyatt Regency on Tuesday Wednesday. On Thursday, registration will be located on the floor behind the elevators in the main lobby of the Hyatt ency.

MS MESSAGE CENTER: Special telephone lines will be alled for incoming, local and long distance calls. Just call the itt Regency, 313/593-1234 and ask for the MSMS Message iter. Be sure you check the Message Center Board in the Exhibit l regularly for posted messages.

AT CHECK: Complimentary coat check will be available icent to the MSMS Registration Desk and will operate at the ie times. Please remember to pick up your coat before going to evening functions. Items left at the coat check will be locked y until the following morning.

MISSION TO COURSES: Admission will be by Course nission Tickets which will be given to physicians when they ster. No one will be admitted to courses without tickets and/or ges. All courses begin promptly at 8:30 a.m. or 1:30 p.m.

CULTY HEADQUARTERS: Course directors and instructors use the Indianapolis Suite on the First Floor (near the pool) as ace to meet, review slides or course material, etc.

SMOKING PLEASE: All participants are asked to refrain n smoking while courses are in session. There will be a half-hour ık in all courses. The no-smoking policy has been in effect since 7.

EE COFFEE: Coffee will be available on Tuesday and Wednes- in the Exhibit Center, and at separate stations near the first and ond floor course rooms on Thursday. Coffee service is provided npliments of the exhibitors and the Michigan Society of Medical istants.

NCHEON TICKETS: Complimentary tickets for Tuesday's Wednesday's Deli lunch and for Thursday's served luncheon are available for paid registrations received in advance of the meeting. A limited number of tickets may still be available for purchase at the Registration Desk.

EXHIBIT CENTER: Participants are urged to visit the outstanding displays featured in the Great Lakes Exhibit Center and to express their support for the exhibitors' financial contribution to the meeting. Exhibits are open Tuesday and Wednesday from 7:30 a.m. to 3:30 p.m. and again from 5:00 p.m. to 6:00 p.m. for an early evening reception sponsored by the exhibitors.

NEW THIS YEAR . . . Free passes are available for registered participants to invite their colleagues and/or staff to visit the exhibit hall on Tuesday. On Thursday, we will feature a new exhibitors networking luncheon. The Exhibit Center will not be open on Thursday.

Daily doorprize drawings will be held, with incentives for visiting the participating booths. A variety of prizes for physicians' personal and professional use have been donated by the exhibitors. Winners will be selected during the afternoon and will be posted during the evening receptions.

CATEGORY I CREDITS: The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

CERTIFICATES OF PARTICIPATION in Category I courses will be provided to physicians at the end of each course. Physicians should keep these certificates on file as proof of their attendance.

MEDIA: Medical writers and representatives of television and radio have been invited to cover the Annual Scientific Meeting. MSMS staff will be available all three days in the Indianapolis Suite to provide assistance.

Capsule Schedule of Annual Scientific Meeting

Monday, November 11

6:00 p.m.
Accent Reduction Seminar

Tuesday, November 12

7:30 a.m.
Registration/Exhibit Hall Open

8:30 a.m.
Office Financial Management Seminar (until noon)

8:30 a.m.
Concurrent Scientific Courses (until noon)

- Basic Cardiac Life Support
- The Breast Lump: Workup and Treatment
- Current Psychiatric Concepts: An Update
- The Medical & Surgical Management of Coronary Occlusive Disease
- Pulmonary Embolism: Etiology, Diagnosis, and Treatment
- Reproductive Endocrinology for the Primary Care Physician
- Rheumatology Update Module
- Traumatic Brain Injury & Spinal Cord Injury
- Treatment of Hyperlipidemia
- Update in Clinical Toxicology

12 Noon
Deli Luncheon for All Registrants

1:30 p.m.
Concurrent Scientific Courses (until 5:00 p.m.)

- Bleeding, Clotting and Transfusion
- Clinical Approaches to HIV
- Fetal Medicine and Surgery in the 90's
- Medical Management of BPH/Female Urology
- Osteoporosis
- Present & Future Issues in Clinical Hypertension
- Radiology for Clinicians
- Resurgence of Tuberculosis
- Sedation and Analgesia for Outpatient & Office Procedures

Wednesday, November 13

7:00 a.m.
FREE "Early Bird" Plenary Session:
"Substance Abuse: The Physician's Role"
Continental Breakfast Included

7:30 a.m.
Registration/Exhibit Hall Open

8:30 a.m.
Concurrent Scientific Courses (until noon)

- A Closer Look at Substance Abuse, Pregnancy, and Its Impact
- Basic Cardiac Life Support
- Common Ophthalmic Problems Faced by the Practicing Physician
- Common Surgical Problems in Infants and Children
- Communicating with the Female Patient Regarding Acute Health Issues
- Concepts & Controversies in Laparoscopic Surgery
- Environmental Issues in Primary Care
- Mastering Common Thyroid Problems: A Case Study Approach
- The Role of DNA Diagnosis in Clinical Practice

12 Noon
Deli Luncheon for All Registrants

Luncheon
Women Physicians

Luncheon
MSMS Committee of Specialty Society Presidents
Sponsored by Michigan Physicians Mutual Liability Company

ednesday, November 13

0 p.m.

ncurrent Scientific Courses *(until 5:00 p.m.)*

- Allergy and Asthma - 1991
- Breast and Prostate Cancer
- Child Abuse Prevention: What Can We Learn From Non-Human Primates
- Dermatological Therapeutics
- How to Choose From Alternative Imaging Techniques
- Physician Services to Nursing Home Residents
- Psychiatric Issues in the Work Place
- Update on Inflammatory Bowel Disease

3:00 p.m.

Board Meeting
Michigan Orthopaedic Society

5:00 p.m.

Reception/Dinner
Michigan Society of General Surgeons

6:00 p.m.

Reception/Dinner
Michigan Occupational Medical Association

Reception/Dinner
Michigan Orthopaedic Society

Reception
Wayne State University Medical Alumni Association

Thursday, November 14

7:00 a.m.

FREE "Early Bird" Plenary Session: "Genetics as the Basis for Medicine in the 21st Century"
Continental Breakfast Included

7:30 a.m.

Registration Open

8:30 a.m.

Concurrent Scientific Courses *(until noon)*

- Attention Deficit Hyperactivity Disorder
- Basic Cardiac Life Support
- Current Approaches to the Management of the Obese Patient
- Current Concepts in Blepharoplasty
- Diagnostic Testing in Back Pain
- Health Risks to Physicians
- Interpretation of Arterial Blood Gases
- Response to Medication in the Elderly
- The Team Physician

12 Noon

Luncheon for All Registrants & Exhibitors

1:30 p.m.

Concurrent Scientific Courses *(until 5:00 p.m.)*

- Addiction or Affliction: The Relationship of Eating Disorders and Chemical Dependency
- Adolescent Sexuality Education
- Biomedical Ethics: Urban Health System Perspectives
- The Clinical Evaluation and Differentiation of the Dementias
- Management of Lower Extremity Injuries in Sports
- Management of the Post MI Patient
- The Resurgence of Childhood Diseases & New Trends in Immunizations: Are Physicians Keeping Pace?
- Selected Topics in Plastic Surgery
- Update on Gestational Diabetes Mellitus

6:00 p.m.

Reception
Michigan Academy of Physical Medicine and Rehabilitation

Reception
Michigan Academy of Plastic Surgeons

Reception
Michigan College of Nuclear Medicine Physicians

TUESDAY MORNING, November 12

All courses run from 8:30 a.m. to noon with a half-hour break

NEW! Invite your staff to attend this half-day course and visit the MSMS Exhibit Hall

Office Financial Management Seminar

Tuesday, November 12, 1991

8:30 a.m. - 12:00 Noon

Marquis Ballroom (2nd Floor)

This program will address accounts receivable management, audit trails, billing and collection procedures, third party payer relations and cash management. The course fee includes deli lunch and admission to the exhibit hall. MMGMA, MSMA and MSMS-A members attend at MSMS member rates. *Non CME course.*

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. Included will be hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver card will be presented upon completion.

COURSE DIRECTOR: **Robert K. Orr, Jr., DO,** Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: **Doctor Orr**

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansing

Doctor Orr

The Breast Lump: Workup and Treatment

PRESENTED BY: Michigan Chapter, American College of Surgeons

A comprehensive approach to diagnosis and treatment of lumps in the breast will be presented, primarily for primary care physicians. Clinical and radiographic diagnosis, biopsy techniques, relevant workup, and treatment of benign and malignant masses will be discussed.

COURSE DIRECTOR: **Angelos Kambouris, MD**, FACS, President, Michigan Chapter, American College of Surgeons

PRESIDING: **Doctor Kambouris**

SPEAKERS:

Doctor Kambouris

Murray Rebner, MD, Henry Ford Hospital, Detroit

U. Raju, MD, Department of Pathology, Henry Ford Hospital, Detr

Robert O'Bryan, MD, Department of Oncology, Henry Ford Hos tal, Detroit

Beth Hummer, MD, Henry Ford Hospital, Detroit

Current Psychiatric Concepts: An Update

PRESENTED BY: Michigan Psychiatric Society

This course will provide primary care physicians with a practical upd on the recognition and treatment of psychiatric problems that a frequently seen in their practices. There will be presentations depression, anxiety, panic disorders and post traumatic stress sy drome.

COURSE DIRECTOR: **Roger F. Haskett, MD,** Associate Profess and Director, Depression Program, Department of Psychiatry, Unive sity of Michigan Medical School

PRESIDING: **Doctor Haskett**

SPEAKERS:

Doctor Haskett

"Depression in Primary Care Practice"

George Curtis, MD, Professor and Director, Anxiety Disorders Pr gram, Department of Psychiatry, University of Michigan Medic School

"Panic Disorder"

Glenn Davis, MD, Chairman, Department of Psychiatry, Henry Fo Hospital, Detroit

The Medical and Surgical Management of Coronary Occlusive Disease

PRESENTED BY: Michigan Society of Thoracic and Cardiovascul Surgeons

This course will outline the developments in anatomy and physiolo that have led to current practice in managing coronary artery diseas The emphasis will be placed on medical and surgical methods managing various forms and degrees of occluded coronary vessel Options and choices available in the 90s will be reviewed and state the art methodologies will be summarized.

COURSE DIRECTOR: **Allan Silbergleit, MD, PhD,** Clinical Profe sor of Surgery and Physiology, Wayne State University School Medicine; Chairman, Division of Thoracic and Cardiovascular Su gery, St. Joseph Mercy Hospital, Pontiac

PRESIDING: **Doctor Silbergleit**

AKERS:

or Silbergleit

rence W. Stephenson, MD, Professor and Chairman, Division of
io-Thoracic Surgery, Wayne State University School of Medicine;
f, Cardio-Thoracic Surgery, Harper Hospital, Detroit

ık Bagnasco, MD, Former Chairman, Division of Cardiology, St.
ph Mercy Hospital, Pontiac

itkumar Patel, MD, Chief of Invasive Cardiology, St. Joseph
:y Hospital, Pontiac

lmonary Embolism: ology, Diagnosis and Treatment

SENTED BY: Michigan College of Emergency Physicians

ıonary Embolism is the leading undiagnosed cause of death. Its
ogy and diagnosis is fraught with difficulties. This course will
:r various treatment modalities including the use of thrombolytic
ıts and mechanical disruption of clots.

JRSE DIRECTOR: **Bradford L. Walters, MD,** FACEP, Henry
l Hospital Emergency Medicine, Michigan College of Emergency
sicians

SIDING: **Doctor Walters**

AKERS:

tor Walters

utine Advances in Pulmonary Embolism Therapy"

rk Rosner, MD, FACEP, Henry Ford Hospital Emergency Medi-
, Detroit

esentation and Diagnosis of Pulmonary Embolism"

ın Cook, MD, Mercy Monroe Medical Center, Monroe

eatment of Pulmonary Embolism"

productive Endocrinology for the imary Care Physician

ESENTED BY: Division of Reproductive Endocrinology and
rtility, Oakwood Hospital, Dearborn

roductive situations commonly encountered in a primary care
:tice will be covered, including evaluation of the infertile couple,
functional uterine bleeding, hormonal contraception including birth
trol pills and Norplant, and premenstrual syndrome.

URSE DIRECTOR: **Maria F. Hayes, MD,** Assistant Professor,
partment of Reproductive Endocrinology, Wayne State University
ool of Medicine; Director, Department of Reproductive Endocri-
ogy, Oakwood Hospital, Dearborn

ESIDING: **Doctor Hayes**

EAKERS:

Doctor Hayes

"Evaluation of the Infertile Couple"

David M. Magyar, DO, Associate Professor, Department of Reproductive Endocrinology, Wayne State University School of Medicine; Director, Division of Reproductive Endocrinology, Oakwood Hospital, Dearborn

"Dysfunctional Uterine Bleeding"

Kenneth A. Ginsburg, MD, Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

"Hormonal Contraception Including Birth Control Pills and Norplant"

Charla M. Blacker, MD, Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

"Premenstrual Syndrome"

Rheumatology Update Module

PRESENTED BY: Department of Rheumatology, University of Michigan Medical School

This course will offer timely topics in rheumatology for practicing Family Physicians and Internists throughout Michigan including updates on Lyme Disease, new treatments for rheumatoid arthritis, back pain, shoulder disorders, reactive arthritis and laboratory testing and rheumatic diseases.

COURSE DIRECTOR: **Mark A. McQuillan, MD,** FACP, Instructor and Rheumatologist, University of Michigan Medical Center

PRESIDING: **Doctor McQuillan**

SPEAKERS:

Doctor McQuillan

"Overview, Lyme Disease Update and Nonsteroidals"

Dianne Trudell, MD, Rheumatology, Private Practitioner, Flint

"Laboratory Testing and Interpretation for the Rheumatic Diseases"

Larry Silverman, MD, Rheumatology, Private Practitioner, Birmingham

"Shoulder Disorder"

Joseph J. Weiss, MD, Rheumatology, Private Practitioner, Livonia

"Knee Pain"

Traumatic Brain Injury and Spinal Cord Injury

PRESENTED BY: Department of Neurological Surgery, Wayne State University School of Medicine

Upon completion of this course participants will be able to identify mechanisms of brain and spinal cord injury, provide initial evaluation of these types of injuries, discuss therapeutic options, and manage transportation and prevention approaches.

COURSE DIRECTOR: **F. G. Diaz, MD, PhD,** Chairman, Department of Neurological Surgery, Wayne State University School of Medicine

PRESIDING: **Doctor Diaz**

SPEAKERS:

William Ganz, MD, Assistant Professor, Department of Neurological Surgery, Wayne State University School of Medicine

"Pathophysiology of Traumatic Brain Injury"

Steven D. Ham, DO, Assistant Professor, Department of Neurological Surgery, Wayne State University School of Medicine

"Management of the Head Injured Child"

Patti Peterson, MD, Associate Professor, Department of Neurology, Wayne State University School of Medicine

"Drug Intervention and Monitoring in Traumatic Brain Injury"

Doctor Diaz

"Evaluation and Management of Spinal Cord Injury"

Treatment of Hyperlipidemia

PRESENTED BY: Division of Endocrinology and Metabolism, Henry Ford Hospital, Detroit

This course will provide information regarding treatment of primary and the most common secondary forms of hyperlipidemia. Selected cases will be discussed by the course faculty, and the audience will be encouraged to present their own cases for discussion.

COURSE DIRECTOR: **Dorothy M. Kahkonen, MD,** Staff Physician, Division of Endocrinology and Metabolism, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Kahkonen**

SPEAKERS:

Carl E. Orringer, MD, Clinical Assistant Professor, Departmen
Internal Medicine, University of Michigan Medical School

"Non-pharmacologic Management of Hyperlipidemia"

J. David Fachnie, MD, Staff Physician, Division of Endocrinol
and Metabolism, Henry Ford Hospital, Detroit

"Pharmacologic Management of Hyperlipidemia"

Doctor Kahkonen

"Treatment of Secondary Hyperlipidemia: Diabetes, Renal Disea

Update in Clinical Toxicology

PRESENTED BY: Blodgett Regional Poison Center, Grand Rap

The course objective is to review the basics in the acute managemen
poisoning and drug overdose. Lead poisoning, tricyclic overd
mushroom intoxication and the use of the clinical toxicology laborat
will be given special emphasis.

COURSE DIRECTOR: **John R. Maurer, MD,** Medical Direc
Blodgett Regional Poison Center, Grand Rapids

PRESIDING: **Doctor Maurer**

SPEAKERS:

Doctor Maurer

"General Management of the Poisoned Patient"

Daniel McCoy, PhD, Co-Director, Blodgett Poison Center, Gr
Rapids

"Laboratory Aspects of Clinical Toxicology"

John Trestrail, RPH, Co-Director, Blodgett Poison Center, Gr
Rapids

"Mushroom Poisoning"

Regine Aronow, MD, Medical Director, Poison Control Cen
Children's Hospital of Michigan, Detroit

All Courses Offer 3 Hours Each of Category I CME Credit.

ESDAY AFTERNOON, November 12

courses run from 1:30 p.m. to 5 p.m. with a half-hour break

eding, Clotting and Transfusion

SENTED BY: Department of Medicine, Hematology Section, igan State University College of Human Medicine

ussion of diagnostic and therapeutic approaches to bleeding and nbotic disorder will be offered through a series of selected cases. and safety of approved and investigational products, such as thrombin III Concentrate, Low Molecular Weight Heparin, Hiru- Factor IX Concentrate and Factor and Factor VII Concentrate will scribed. Emphasis also will be placed on guidelines for appropri- se of blood cell concentrates.

URSE DIRECTOR: **John A. Penner, MD,** Professor, Department ledicine, Hematology Section, Michigan State University

SIDING: **Doctor Penner**

AKERS:

tor Penner

ri Hassouna, MD, PhD, Department of Medicine, Hematology ion, Michigan State University

tal Medicine and Surgery in the 90s

SENTED BY: Division of Reproductive Genetics, Wayne State versity School of Medicine and Hutzel Hospital, Detroit

t leaps in technology now allow early identification of fetuses with genital anomalies. Techniques to operate on the fetus to correct omical anomalies such as obstructed bladders and diaphragmatic ias and to pioneer attempts to insert new genetic material for fetuses ure themselves will be discussed.

URSE DIRECTOR: **Mark I. Evans, MD,** Professor, Department bstetrics and Gynecology and Molecular Biology & Genetics, yne State University School of Medicine and Hutzel Hospital, roit

SIDING: **Doctor Evans**

AKERS:

tor Evans

rk P. Johnson, MD, Assistant Professor, Department of Obstetrics Gynecology, Molecular Biology and Genetics, Wayne State Uni- sity School of Medicine

lfgang Holzgreve, MD, Professor, Department of Obstetrics and ecology, Westfalische Wilhelms - University Munster, Federal ublic of Germany

inical Approaches to HIV

ESENTED BY: MSMS AIDS Provider Education Project

s course will outline testing procedures for HIV infected patients. initial evaluation and laboratory testing of HIV infected patients the use of anti-retroviral drugs (AZT, ddI, ddC). Approaches to diagnosis and treatment of common opportunistic infection (Pneumocystis, CMV, Cryptococcus), diagnosis and treatment of HIV-associated malignancies and prophylactic medications for health care workers will be reviewed.

COURSE DIRECTOR: **David B. Martin, MD,** Chairman, MSMS AIDS Provider Education Project

PRESIDING: **Doctor Martin**

SPEAKERS:

Evelyn J. Fisher, MD, Senior Staff Physician, Division of Infectious Diseases, Henry Ford Hospital, Detroit

Donald H. Batts, MD, Upjohn Company, Kalamazoo

Davis S. Davenport, MD, Medical Director, Infection Control Services, Bronson Medical Center, Kalamazoo

Paula Schuman, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine

Medical Management of BPH/Female Urology

PRESENTED BY: Michigan Urological Society

The objective of this course is to give primary care physicians an overall description of Benign Prostatic Hyperplasia and common urological signs and symptoms of middle-aged males and elderly females. Clinical evaluation and management techniques will be discussed.

COURSE DIRECTOR: **James O. Peabody, MD,** Urologist, Henry Ford Hospital

PRESIDING: **Doctor Peabody**

SPEAKERS:

Aaron Kirkemo, MD, Director of Urodynamics, Henry Ford Hospital, Detroit

"Medical Management of BPH"

S. D. Shetty, MD, Fellow, Department of Urology/Oncology, Henry Ford Hospital, Detroit

"Role of PSA in Detection and Treatment of Prostate Cancer"

Doctor Peabody

"Role of Prostate Ultrasound in Detection and Management of Prostate Cancer"

David A. Burks, MD, Senior Staff Urologist, Henry Ford Hospital, Detroit

"Evaluation and Treatment of Urinary Incontinence in the Elderly"

Caleb Fleming, MD, Senior Staff Urologist, Henry Ford Hospital, Detroit

"Advances in the Diagnosis and Management of the Infertile Male"

Edward Messing, MD, Professor, Department of Urology, Medical College of Wisconsin

"Evaluation of Hematuria"

Osteoporosis

PRESENTED BY: Department of Internal Medicine, Henry Ford Hospital

This course will include an overview of non-invasive bone mass measurements, clinical evaluation and management techniques including hormone replacement therapy at menopause, for osteoporosis.

COURSE DIRECTOR: **Henry Bone, MD,** Senior Staff Physician, Bone and Mineral Division, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Bone**

SPEAKERS:

Brahm Shapiro, MD, MB, CLB, Professor, Department of Nuclear Medicine, University of Michigan Medical School

"Bone Mass Measurement"

David Rovner, MD, Professor, Department of Endocrinology, Michigan State University College of Human Medicine, East Lansing

"Hormone Replacement for the Menopause"

Doctor Bone

"Evaluation and Management of Osteoporosis"

Present and Future Issues in Clinical Hypertension

PRESENTED BY: Department of Internal Medicine, Henry Ford Hospital, Detroit

This course will discuss indications for treatment of high blood pressure and factors specific for population groups (women, the black population, young adults, etc.), when to evaluate for and how to detect renal artery stenosis, and how to preserve renal function when it is impaired in high blood pressure. The importance of insulin, calcium, potassium and magnesium while treating high blood pressure will be highlighted as a future issue in clinical hypertension.

COURSE DIRECTOR: **Max Wisgerhof, MD,** Division of Endocrinology and Metablism, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Wisgerhof**

SPEAKERS:

Kenneth Jamerson, MD, Hypertension Section, University of Michigan

"When to Treat High Blood Pressure, How to Monitor Effects of Treatment, and Considerations for Particular Populations"

Susan Steigerwalt, MD, Acting Head, Hypertertension Section, Henry Ford Hospital, Detroit

"Renal Vascular Hypertension and Preserving Renal Function in High Bloodpressure"

James Sowers, MD, Head, Division of Endocrinology and Hypertension, Wayne State University School of Medicine

"The Influence of Insulin and Cations in High Blood Pressure"

Radiology for Clinicians

PRESENTED BY: Michigan Radiological Society and Departmen Radiology, Wayne State University School of Medicine and Har Hospital, Detroit

This course will provide clinicians with information on the approach common clinical problems using radiologic modalities or indicatio Magnetic resonance imaging, prostate ultrasound, color doppler ima ing and intervention radiology uses and abuses will be discussed.

COURSE CO-DIRECTORS: **A. P. Zingas, MD,** Associate Profess Department of Radiology, Wayne State University School of Medici and Michigan Radiological Society and **George A. Kling, MD,** Cha man, Department of Radiology, Wayne State University School Medicine

PRESIDING: **Doctor Zingas**

SPEAKERS:

Mark Segel, MD, Assistant Professor, Department of Radiolog Wayne State University School of Medicine

"Radiologic of the Evaluation of the Prostate"

Beatrice Madrazo, MD, Radiologist, William Beaumont Hospit Royal Oak

"Color Doppler Imaging"

Renate Soulen, MD, Professor, Department of Radiology, Way State University School of Medicine

"Magnetic Resonance Imaging"

Resurgence of Tuberculosis

PRESENTED BY: Department of Pulmonary and Critical Ca Medicine, William Beaumont Hospital, Royal Oak

The atypical presentation of tuberculosis, including diagnosis, path ogy, pathogenesis, and management will be discussed, includi protection and prophylaxis against tuberculosis in the face of the AI epidemic.

COURSE DIRECTOR: **K. P. Ravikrishnan, MD,** Director, Pulm nary and Critical Medicine, William Beaumont Hospital, Royal Oa

PRESIDING: **Doctor Ravikrishnan**

SPEAKERS:

Marcus Zervos, MD, Department of Infectious Diseases, Willia Beaumont Hospital, Royal Oak

"Epidemiology of Tuberculosis in the Face of AIDS Epidemic"

Dana Kissner, MD, Department of Pulmonary Medicine, Wayne Sta University School of Medicine

"Diagnosis and Management of Tuberculosis"

Doctor Ravikrishnan

"Resurgence of Tuberculosis; Introduction and Pathogenesis of T berculosis"

lation and Analgesia for Outpatient l Office Procedures

SENTED BY: Michigan Society of Anesthesiologists

n completion of this course, participants will be familiar with a ty of techniques involved in sedation and analgesia for outpatient office procedures. Practical patient selection techniques will be ided.

RSE DIRECTOR: **Georgine M. Steude, MD,** President, Michi- Society of Anesthesiologists

SIDING: **Doctor Steude**

AKERS:

rles Schmitter, MD, Director Outpatient Anesthesia, Department nesthesiology, St. Joseph Mercy Hospital, Ypsilanti

oosing Patients and Procedures and Monitoring Personnel and ipment for Surgicenters and Offices"

Bert Bez, DO, Chief of Anesthesia, Department of Anesthesiology, Ingham Medical Center, Lansing

"Developing Criteria for IV Sedation in the Hospital by Non-Anesthesiologists"

Steven Slack, MD, Staff Anesthesiologist, Department of Anesthesiology, St. Joseph Mercy Hospital, Ypsilanti

"Anesthesia for Office Procedures"

Gaylord D. Alexander, MD, Director of Operating Rooms, Department of Anesthesiology, Sinai Hospital of Detroit

"Techniques of Sedation and Monitoring"

Niall Wilton, MD, Assistant Professor, Department of Anesthesiology, University of Michigan Medical School

EDNESDAY MORNING, November 13

No Charge for this "Early Bird" Plenary Session

Substance Abuse: The Physician's Role

Continental Breakfast at 7:00 am.
Presentation at 7:15 a.m.
Hubbard Ballroom (1st Floor)

Charles C. Vincent, MD, Associate Professor, Department of Obstetrics and Gynecology; Vice-Chief of Staff and Chief, Division of General Gynecology, Hutzel Hospital, Detroit

The material presented in this course will be supplemented by displays showcasing various community drug education projects and MSMS programs to assist the impaired physician. There is no fee for the Plenary session and it offers 1 hour of Category I CME credit.

All courses run from 8:30 a.m. to noon with a half-hour break

A Closer Look at Substance Abuse, Pregnancy and Its Impact

PRESENTED BY: Department of Gynecology, Hutzel Hospital

This course will compliment the morning's plenary session on Substance Abuse: The Physician's Role. It will further analyze the specific problems associated with substance abuse, pregnancy, and the overall impact on society. Specific emphasis will be given to the screening process and current therapy from both the maternal and fetal perspective, the association of substance abuse and HIV positivity, and the societal effect of this problem.

COURSE DIRECTOR: **Charles C. Vincent, MD,** Associate Professor, Department of Obstetrics and Gynecology; Vice-Chief of Staff and Chief, Division of General Gynecology, Hutzel Hospital, Detroit

PRESIDING: **Doctor Vincent**

SPEAKERS:

James N. Wardell, MD, Clinical Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

"Substance Abuse and Pregnancy, Who Should be Screened and Current Management"

Enrique M. Ostrea, Jr., MD, Chief, Department of Pediatrics, Hutzel Hospital, Detroit

"Substance Abuse and the Newborn – The Hutzel Experience"

Curtiz D. Meriwether, MD, Associate Professor, Department of Obstetrics and Gynecology, Hutzel Hospital, Detroit

"The New Triad – Substance Abuse, Pregnancy and AIDS"

David Fukazawa, Director of Human Needs Division, New Detroit

"The Effects of Substance Abuse on Michigan's Largest City"

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. Included will be hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver card will be presented upon completion.

COURSE DIRECTOR: **Robert K. Orr, Jr., DO,** Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: **Doctor Orr**

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansi

Doctor Orr

Common Ophthalmic Problems Faced by the Practicing Physician

PRESENTED BY: Michigan Ophthalmological Society

This course will teach primary care physicians how to manage t common ophthalmic problems they encounter. Specific topics to addressed include: the ophthalmic screening examination, importa procedures, ophthalmic emergencies, common ophthalmic sympto and signs, the red eye, and the eye in systemic disease.

COURSE DIRECTOR: **Jonathan D. Trobe, MD,** Professor, Depa ment of Ophthalmology and Associate Professor, Department of Ne rology, University of Michigan Medical School and Kellogg E Center, Ann Arbor

PRESIDING: **Doctor Trobe**

SPEAKERS:

Doctor Trobe

Mark W. Johnson, MD, Assistant Professor, Department of Ophtha mology, University of Michigan Medical School and Kellogg E Center, Ann Arbor

Christine Nelson, MD, Assistant Professor, Department of Ophtha mology, University of Michigan Medical School and Kellogg E Center, Ann Arbor

H. Kaz Soong, MD, Associate Professor, Department of Ophthalm ogy, University of Michigan Medical School and Kellogg Eye Cente Ann Arbor

Common Surgical Problems in Infants and Children

PRESENTED BY: Section of Pediatric Surgery, University of Mich gan Medical School

This course will instruct primary care physicians, pediatricians, a general surgeons in the common surgical problems seen in infants a children. The definitive management of many of these problems w be discussed and those cases that require referral to a tertiary ca facility will be described.

COURSE DIRECTOR: **Arnold G. Coran, MD,** Professor, Depar ment of Surgery and Head, Section of Pediatric Surgery, University Michigan Medical Center

PRESIDING: **Doctor Coran**

SPEAKERS:

Doctor Coran

"Abdominal Pain In Children"

Theodore Z. Polley, Jr., MD, Assistant Professor, Department Pediatric Surgery, University of Michigan Medical Center

"Pediatric Trauma"

ert E. Cilley, MD, Assistant Professor, Department of Pediatric gery, University of Michigan Medical Center

guinal Hernias In Children"

ald B. Hirschl, MD, Assistant Professor, Department of Pediatric gery, University of Michigan Medical Center

dominal Masses In Children"

mmunicating with the Female Patient garding Acute Health Issues

ESENTED BY: MSMS Committee on Concerns of Women sicians

on completing this course all physicians will be better informed on ective communication skills, particularly regarding acute health ies in the female patient, such as abnormal pap smears, abnormal mmographies, premenstrual syndrome, and depression.

URSE DIRECTOR: **Martha L. Gray, MD,** Chairman, MSMS mmittee on Concerns of Women Physicians

ESIDING: **Doctor Gray**

EAKERS:

sley Beemer, MD, Staff Gynecologist, Department of Obstetrics Gynecology, Catherine McAuley Health Center, Ypsilanti

ommunicating with the Female Patient Regarding the Abnormal p Smear"

rbara Threatt, MD, Director, Comprehensive Breast Center, Ann bor

ommunicating with the Female Patient Regarding the Abnormal mmogram"

nice L. Werbinski, MD, Bronson Women's Health Center, Kalam-oo

ommunicating with the Female Patient Regarding PMS and De-ession"

oncepts and Controversies in aparoscopic Surgery

ESENTED BY: Department of Surgery, Michigan State University llege of Human Medicine

is course will present information describing new frontiers in aroscopic surgery. An evaluation of laparoscopic procedures for olecystectomy, various gynecologic procedures, pediatric surgeries, rnia repair, and appendectomy will be included.

OURSE DIRECTOR: **Keith Apelgren, MD,** Associate Professor, epartment of Surgery, Michigan State University College of Human edicine

RESIDING: **Doctor Apelgren**

EAKERS:

Doctor Apelgren

"Laparoscopic Cholecystectomy: The New Gold Standard?"

Ed Auston, MD, Clinical Associate Professor, Department of Surgery, Michigan State University College of Human Medicine

"Complications of Laparoscopic Cholecystectomy"

James Babel, MD, Clinical Assistant Professor, Department of Surgery, Michigan State University College of Human Medicine

"Gynecologic Procedures Done Laparoscopically"

Phil Dennis, MD, Associate Professor, Department of Surgery, Michigan State University College of Human Medicine

"Pediatric Laparoscopic Surgery"

Donald Reed, MD, Clinical Assistant Professor, Department of Surgery, Michigan State University College of Human Medicine

"Laparoscopic Hernia Repair and Appendectomy"

Harold Sauer, MD, Associate Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine

"Frontiers of Laparoscopic Surgery"

Environmental Issues in Primary Care

PRESENTED BY: MSMS Task Force on Environmental Health Issues

This course will provide information on indoor and outdoor environmental hazards, with an emphasis on those affecting children and women of childbearing age, including lead, mercury and pesticides.

COURSE DIRECTOR: **Robert M. Soderstrom, MD,** Chairman, MSMS Task Force on Environment and Health

PRESIDING: **Doctor Soderstrom**

SPEAKERS:

Regine D. Aronow, MD, Director, Southeastern Michigan Regional Poison Control Center, Detroit

"Lead Poisoning – Changing Pictures, Changing Standards"

Doctor Aronow

"Common Pesticide Problems"

Charles Cubbage, PhD, Michigan Department of Agriculture, Lansing

"Pesticide Regulation"

Mastering Common Thyroid Problems: A Case Study Approach

PRESENTED BY: Michigan Thyroid Association and Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak

This course, utilizing primarily illustrative cases, will enable primary care physicians to handle similar patient problems in their practices. Topics to be covered in this course include hyperthyroidism, thyroid nodules, thyroid cancer, problems in thyroid function test interpretation, and thyroid hormone replacement therapy.

COURSE DIRECTOR: **Donald A. Meier, MD,** President, Michigan Thyroid Association; Physician, Department of Nuclear Medicine, William Beaumont Hospital, Troy and Associated Endocrinologists, West Bloomfield

PRESIDING: **Doctor Meier**

SPEAKERS:

John E. Freitas, MD, Clinical Associate Professor, Department of Internal Medicine, University of Michigan Medical School and Wayne State University School of Medicine; Staff Physician, William Beaumont Hospital, Royal Oak

"Nodular Goiter - Medical Perspectives"

Gary B. Talpos, MD, Endocrine Surgeon, Department of Surgery, Henry Ford Hospital, Detroit

"Nodular Goiter - Surgical Perspective"

Charles I. Taylor, MD, Associated Endocrinologists, West Bloomfield

"Hyperthyroidism: Problems with Diagnosis and Therapy"

Doctor Meier

"Avoiding Problems in Thyroid Function Test Interpretation"

The Role of DNA Diagnosis in Clinical Practice

PRESENTED BY: Department of Pediatrics, Wayne State University School of Medicine and Children's Hospital of Michigan

Recent advances in DNA technology have led to an enormous incre in the knowledge of various chronic and debilitating diseases, whic being applied in diagnosis, carrier detection and clinical counseli This course will provide primary care physicians with an overview the implications and use of DNA analysis in clinical practice.

COURSE DIRECTOR: **Erawati V. Bawle, MD,** Associate Profess Department of Pediatrics and Chief, Division of Genetics/Metabolis Wayne State University School of Medicine and Children's Hospital Michigan

PRESIDING: **Doctor Bawle**

SPEAKERS:

Charles R. Scriver, MD, Professor, Department of Biology, Hum Genetics and Pediatrics, McGill University Faculty of Medici Montreal

"Examples of DNA Diagnosis in Families"

Orlando J. Miller, MD, Chairman, Department of Molecular Biolo and Genetics, Wayne State University School of Medicine

"The ABC's of Clinical Molecular Genetics"

Janice Bach, MS, Genetics Consultant, Children's Special Heal Care Services, Michigan Department of Public Health, Lansing

"DNA Testing for Your Patients: Access Through Genetic Centers Michigan"

Doctor Bawle

"My Experiences Using Molecular Genetics in Pediatric Practice"

WEDNESDAY AFTERNOON, November 13

All courses run from 1:30 p.m. to 5 p.m. with a half-hour break

Allergy and Asthma - 1991

PRESENTED BY: Michigan Allergy Society

This course will present current concepts in the pathophysiology and management of allergic rhinitis, the role of immunotherapy in bronchial asthma, as well as a review of the possible role of food additives in allergic disease for physicians who care for patients with allergic diseases.

COURSE DIRECTOR: **James G. Fordyce, MD,** President-Elect, Michigan Allergy Society

PRESIDING: **Doctor Fordyce**

SPEAKERS:

Alkis G. Togias, MD, Assistant Professor, Department of Medicine, Division of Clinical Immunology, Johns Hopkins School of Medicine, Baltimore, MD

"The Management of Allergic Rhinitis - Implications for Upper an Lower Airways"

John L. Ohman, Jr., MD, Assistant Clinical Professor, Department Medicine, Tufts University School of Medicine; Chief, Allergy Clini and Director, Allergy Research Laboratory, Boston, Massachusetts

"Allergen Immunotherapy in Asthma"

John A. Anderson, MD, Clinical Professor, Department of Pediatric University of Michigan School of Medicine; Head, Division of Allerg and Clinical Immunology, Henry Ford Hospital, Detroit

"Suspected Reactions to Food Additives - A Review"

east and Prostate Cancer

SENTED BY: Michigan Chapter, American Cancer Society

T purpose of this course will be to update primary care physician's k wledge on breast and prostate cancer, to include information on i dence, risk factors, prevention and the latest in diagnostic tech- n es.

URSE CO-DIRECTORS: **Carol Slomski, MD,** Assistant Profes- s Department of Surgery, Michigan State University College of nan Medicine and **G. Marie Swanson, PhD,** Professor, Depart- it of Medicine, Michigan State University College of Human dicine; Director, Cancer Center at Michigan State University and e President, American Cancer Society, Michigan Division.

ESIDING: **Doctor Swanson**

EAKERS:

ctor Slomski

reast Cancer Prevention - Diagnosis - Treatment"

vid Wartinger, DO, Assistant Professor, Department of Urology, chigan State University College of Osteopathic Medicine

rostate Cancer"

ctor Swanson

ıcidence and Risk Factors of Breast Cancer"

hild Abuse Prevention: What Can We Learn om Non Human Primates

ESENTED BY: Department of Pediatrics and Human Develop- nt, Michigan State University College of Human Medicine

e objectives of this course are to review why non human primates in otivity become extremely abusive and neglectful of their offspring, summarize how primatologists and zoo professionals corrected these oblems, and to discuss the applicability of these interventions in mans.

URSE DIRECTOR: **Ray E. Helfer, MD,** Professor, Department Pediatrics and Human Development, Michigan State University llege of Human Medicine

ESIDING: **Doctor Helfer**

EAKER:

octor Helfer

ermatological Therapeutics

RESENTED BY: Michigan Dermatological Society

is course will instruct and review for primary care, consulting ysicians and dermatologists both time-honored and new therapeutic odalities. In addition, an update on basic surgical therapy tips will be ndered.

COURSE DIRECTOR: **O. G. Rodman, MD,** Vice Chairman, Department of Dermatology, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Rodman**

SPEAKERS:

Kenneth E. Greer, MD, Professor, Department of Dermatology, University of Virginia School of Medicine, Charlottesville

"Sulfone Update"

Timothy Johnson, MD, Assistant Clinical Professor, Department of Dermatology, University of Michigan Medical School

"Basic Therapeutics in Dermatological Surgery"

Stuart Maddin, MD, FRCPC, Division of Dermatology, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada

"Current Dermatologic Therapy"

How to Choose From Alternative Imaging Techniques

PRESENTED BY: Department of Radiology, Michigan State University College of Human Medicine

This course will discuss the relative role of nuclear medicine, CT, MRI, ultrasound and mammography in current medical practice. The role of magnetic resonance imaging relative to computed tomography will be emphasized as well as the role of magnetic resonance angiography versus invasive angiography in diagnosing vascular disease.

COURSE DIRECTOR: **E. James Potchen, MD,** Chairperson, Department of Radiology, Michigan State University College of Human Medicine

PRESIDING: **Doctor Potchen**

SPEAKERS:

David Gift, MS, Specialist, Economics; Department of Radiology, Michigan State University, College of Human Medicine

"Present Status of Clinical Magnetic Resonance"

Arlene Sierra, MPA, Director of Clinical Services, Department of Radiology, Michigan State University College of Human Medicine

"Current Status of Stereotaxic Fine-Needle Aspiration for Nonpalpable Breast Cancer"

Alexander Gottschalk, MD, Professor, Department of Nuclear Medicine, Michigan State University College of Human Medicine

"Present Status of Diagnostic Nuclear Medicine Procedures"

Atis Freimanis, MD, Professor, Department of Radiology, Michigan State University College of Human Medicine

"Present Status of Ultrasonic Diagnosis in Medicine"

Joseph Pernicone, DO, PhD, Assistant Professor, Department of Radiology, Michigan State University College of Human Medicine

"Present Status of Magnetic Resonance Angiography"

Physician Services to Nursing Home Residents

PRESENTED BY: MSMS Committee on Aging

This course will include a panel discussion of the problems physicians face when serving the needs of nursing home patients, including the Michigan Department of Public Health requirements, insights and suggestions for changing the physicians practice environment in the nursing home, and the patient's needs expectations.

COURSE DIRECTOR: **James G. O'Brien, MD,** Chairman, MSMS Committee on Aging

PRESIDING: **Doctor O'Brien**

SPEAKERS:

David J. Young, MD, Internal Medicine Associates of Holland

Daniel McNeil, MD, Internal Medicine Associates of Holland

John F. Strandmark, MD, Medical Director, Ingham County Medical Care Facility

Donald Bentsen, President and CEO, Michigan Non-Profit Homes Association

Beth Bacon, Vice President, Michigan Non-Profit Homes Association

Charles E. Harmon, Executive Vice President, Health Care Association of Michigan

Helen Wentz, Assistant Vice President, Health Care Association of Michigan

Hollis Turnham, Michigan Long-Term Care Ombudsman, Citizens for Better Care

Evelyn K. Jones, Division Chief, Licensing and Certification, Michigan Department of Public Health

This program has been reviewed and is acceptable for 3 Prescribed Hours by the American Academy of Family Physicians.

Psychiatric Issues in the Work Place

PRESENTED BY: Michigan Occupational Medical Association

This course will instruct primary and consulting physicians in the magnitude and assessment of psychiatric problems in the work place, to include means to distinguish dual diagnoses of substance abuse and psychiatric disease, factors contributing to psychiatric disability and work place stress, and the role of psychological and neuropsychological testing.

COURSE DIRECTOR: **John J. Bernick, MD, PhD,** Michigan Occupational Medical Association, Dearborn

PRESIDING: **Doctor Bernick**

SPEAKERS:

R. Beale, MD, Health Alliance Plan, Detroit

"Psychiatric Utilization Statistics"

Cleon Michael, MD, Psychiatry, Private Practice, Ann Arbor

"Stress in the Work Place"

Robert Niccolini, MD, Department of Psychiatry, Wayne State U versity School of Medicine

"Substance Abuse"

Anthony Petrilli, MD, Clinical Assistant Professor, Department Psychiatry, Wayne State University School of Medicine

"Neuropsychological Testing"

Update on Inflammatory Bowel Disease

PRESENTED BY: Michigan Society of Colon and Rectal Surgeo

This session will update physicians on historical perspectives a newer approaches to inflammatory bowel disease.

COURSE DIRECTOR: **Steven E. Olchowski, MD,** President, Mich gan Society of Colon and Rectal Surgeons, St. Clair Shores

PRESIDING: **Doctor Olchowski**

SPEAKERS:

Rene Peleman, MD, Department of Internal Medicine, Universi Health Center, Ann Arbor

"Overview of Inflammatory Bowel Disease"

Che Song Park, MD, Clinical Associate Professor, Department Surgery, Michigan State University College of Human Medicine

"Diagnosis and Management of Anal Manifestation of Crohn's Di ease"

John M. MacKeigan, MD, Colon and Rectal Surgeon, Ferguso Clinic, Grand Rapids

"Surgical Management of Crohn's Disease"

Jason Bodzin, MD, Colon and Rectal Surgeon, Children's Hospit of Michigan, Detroit

"Surgical Management of Ulcerative Colitis"

Richard Jaszewski, MD, Allen Park V.A. Hospital

"What's New and on the Horizon in Management of Inflammato Bowel Disease"

HURSDAY MORNING, November 14

No Charge for this "Early Bird" Plenary Session

Genetics as the Basis for Medicine In the 21st Century

Continental Breakfast at 7:00 am.
Presentation at 7:15 a.m.
Hubbard Ballroom (1st Floor)

Francis S. Collins, MD, PhD, Professor of Genetics and Internal Medicine, University of Michigan, and Investigator, Howard Hughes Medical Institute

This session complements the half-day session on "The Role of DNA Diagnosis" offered on Wednesday morning. There is no fee for the Plenary session and it offers 1 hour of Category I CME credit.

l courses run from 8:30 a.m. to noon with a half-hour break

ttention Deficit Hyperactivity Disorder

ESENTED BY: Michigan Academy of Family Physicians

scussion will include the definition of Attention Deficit Hyperactiv- Disorder (ADHD) and its principal characteristics. Evaluation hniques and diagnostic criteria will be explored. Principles of ervention and treatment including drug therapy, child/parent coun- ing, and teacher/parent education also will be presented.

URSE DIRECTOR: **Miriam S. Daly, MD,** Private Practitioner, bion; Michigan Academy of Family Physicians

ESIDING: **Doctor Daly**

EAKERS:

aniel Nolan, PhD, Private Practice, Child Psychology, Ann Arbor

mes Dillan, MD, Child and Adolescent Psychiatry Hospital, Univer- y of Michigan School of Medicine

asic Cardiac Life Support

ESENTED BY: St. Lawrence Hospital and Michigan College of nergency Physicians

is course will include lectures and practical situations for teaching asic Cardiac Life Support according to the American Heart Associa- n guidelines. Included will be hands-on teaching of cardiopulmo- ry resuscitation, obstructed airways in unconscious and conscious ctims, including infants, and CPR. A BCLS card or Heart Saver card ill be presented upon completion.

COURSE DIRECTOR: **Robert K. Orr, Jr., DO,** Vice Chief, Department of Emergency Medicine Services, St. Lawrence Hospital, Lansing

PRESIDING: **Doctor Orr**

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansing

Doctor Orr

Current Approaches to the Management of the Obese Patient

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School

This course will review current concepts of the pathophysiology and medical complications of obesity, guidelines for safe weight loss, strategies for developing an effective weight loss program, and the importance of genetic, thermogenic and biochemical factors in the development of obesity. Some of the major complications will be discussed including diabetes, hypertension, sleep apnea and osteoarthrosis.

COURSE DIRECTOR: **David E. Schteingart, MD,** Professor, Department of Internal Medicine, University of Michigan Medical School

PRESIDING: **Doctor Schteingart**

SPEAKERS:

Doctor Schteingart

"Current Approaches to the Diagnosis and Management of the Obese Patient"

Judy Tomer, RD, Clinical Dietitian, Nutrition Counseling Center, University of Michigan Medical School

"Use of Diet Diaries and Very Low Calorie Diets in the Management of Obesity"

Gloria Edwards, PhD, Chief Social Worker, Division of Internal Medicine, University of Michigan Medical School

"Psychosocial Evaluation and Behavioral Management of the Obese Patient"

Richard M. Lampman, PhD, Adjunct Associate Professor, Exercise Physiology, University of Michigan Medical School and School of Public Health

"The Exercise Prescription for Patients with Severe Obesity"

Current Concepts in Blepharoplasty

PRESENTED BY: Division of Plastic Surgery, Henry Ford Hospital, Detroit

The anatomy of the eyelids will be correlated with the evaluation of patients desiring cosmetic surgery. Classic as well as newer surgical approaches will be discussed in detail. This program is directed to practicing Plastic Surgeons, Ophthalmologists, and residents in training.

COURSE DIRECTOR: **Donald M. Ditmars, Jr., MD,** Division Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Ditmars**

SPEAKERS:

Paul H. Izenberg, MD, Head, Division of Plastic and Reconstructive Surgery, St. Joseph Mercy Hospital, Ypsilanti

"Anatomy of Eyelid/Orbital Adnexa"

Glen W. Jelks, MD, FACS, Associate Professor, Department of Plastic Surgery and Associate Professor, Department of Ophthalmology, New York University School of Medicine, New York

"Transconjunctival Blepharoplasty"

"Lateral Canthoplasty"

"Evaluation for Blepharoplasty"

Diagnostic Testing in Back Pain

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

This course will provide the practitioner with an understanding of functional anatomy of the lumbar spine. The roles of diagnos imaging (CT, MRI), electrodiagnostic testing, (EMG, SSEP), a functional motion and strength testing will be discussed.

COURSE DIRECTOR: **Gary Chodoroff, MD,** Clinical Associ Professor, Department of Rehabilitation Medicine, Wayne State U versity School of Medicine

PRESIDING: **Doctor Chodoroff**

SPEAKERS:

Doctor Chodoroff

"Functional Anatomy of Lumbar Spine"

Michael L. Schwartz, MD, Chairman, Department of Radiolo Sinai Hospital

"Diagnostic Imaging of the Spine"

Kenneth Richter, DO, Section Chief, Department of Physical Me cine and Rehabilitation, Providence Hospital, Southfield

"Electrodiagnostic Testing in Spinal Disorders"

Michael Leither, PT, Director of Physical Therapy, Physic Therapeutix, Redford

"Functional Testing in Low Back Pain"

Health Risks to Physicians

PRESENTED BY: Departments of Internal Medicine and Medic Education, Oakwood Hospital, Dearborn

Through the years, physicians have been subjected to many risks as th care for their patients. This course will place current risks in historic perspective and review three major modern health risks to physiciar Hepatitis B, AIDS and substance abuse.

COURSE DIRECTOR: **Nicholas J. Lekas, MD,** Clinical Associa Professor, Department of Medicine, Wayne State University School Medicine

PRESIDING: **Doctor Lekas**

SPEAKERS:

Alexander Walt, MB, ChB, Distinguished Professor, Department Surgery, Wayne State University

"Historical and Philosophical Prospectives of Modern Health Risk

Doctor Lekas

"Hepatitis B as a Health Risk to Physicians"

Lawrence Crane, MD, Associate Professor, Department of Medicin Wayne State University School of Medicine and Chief, Infectio Diseases, Harper Hospital, Detroit

"AIDS as a Health Risk to Physicians"

Douglas McDonald, MD, Senior Vice-President, Medical Directo Oxford Institute, Oxford

"Substance Abuse as a Health Risk to Physicians"

erpretation of Arterial Blood Gases

SENTED BY: Department of Critical Care Medicine and Pulmo- Medicine, St. Mary Hospital, Livonia

course will cover basic concepts of acid base physiology, ventila- and oxygenation. Participants will then evaluate a detailed and odical approach for the interpretation of arterial blood gases.

JRSE DIRECTOR: **B. Babu Paidipaty, MD,** Director, Depart- t of Critical Care Medicine and Pulmonary Medicine, St. Mary oital, Livonia

SIDING: **Doctor Paidipaty**

AKERS:

tor Paidipaty

ysiology of Ventilation and Oxygenation"

ies Krause, MD, Associate Professor, Department of Medicine, ne State University School of Medicine and Director of Medical , Detroit Receiving Hospital

ysiology of Acid Base"

tors Paidipaty and Krause

erpretation of Arterial Blood Gases"

sponse to Medication in the Elderly

ESENTED BY: Department of Family Medicine, Wayne State versity School of Medicine

s course will focus on the pharmacologic aspects of aging. Specific ntion will be paid to common drug problems, drug interactions, and use of psychotropic medications under the new OBRA guidelines.

URSE DIRECTOR: **Ray A. Breitenbach, MD, MS,** Associate fessor, Department of Family Medicine, Wayne State University ool of Medicine

ESIDING: **Doctor Breitenbach**

EAKERS:

ice Deshere, MD, Director, Department of Geriatrics, Wayne State iversity School of Medicine

edications and Elders: A Delicate Balance"

Elizabeth Arnold, MD, Geriatric Senior Assessment, Grace Hospital, Detroit

"Principles of Prescribing in the Elderly"

Doctor Breitenbach

"OBRA Regulations in the Nursing Home"

The Team Physician

PRESENTED BY: Michigan Orthopaedic Society and Orthopaedic Surgery Associates, P.C., Ypsilanti

The course is designed to instruct primary care physicians acting as team physicians especially regarding on the field recognition and management of head and neck injuries, equipment for the team physicians bag, and the standards and value of preparticipation physicals.

COURSE DIRECTOR: **William M. Heston, MD,** Chairperson, Program Committee, Michigan Orthopaedic Society, Ypsilanti

PRESIDING: **Waldomar M. Roeser, MD,** Orthopaedic Surgeon and Team Physician, Eastern Michigan University, Ypsilanti

SPEAKERS:

Derek Mackesy, MD, CMO, Primary Care Physician and Team Physician, Canadian Olympic Hockey Team 1985-1992

"The Role of the Team Physician"

David H. Janda, MD, Director, Institute for Preventative Sports Medicine; Orthopaedic Surgeon, Catherine McCauley Health Center and University of Michigan Medical School

"The Athletes Shoulder"

Doctor Roeser

"The Athletes Wrist and Head"

Doctor Mackesy

"Recognition and Management of Head and Back Injuries"

All Courses Offer 3 Hours Each of Category I CME Credit.

THURSDAY AFTERNOON, November 14

All courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break

Addiction or Affliction: The Relationship of Eating Disorders and Chemical Dependency

PRESENTED BY: Department of Psychiatry, University of Michigan Medical School

Recently, many clinicians have noted the high incidence of alcoholism in patients with eating disorders and the high incidence of eating disorders in women with alcoholism. This course will highlight the relationship of these disorders for primary clinicians, present epidemiologic and laboratory data to support this relationship, provide diagnostic screens for primary care physicians to use, and will discuss implications of this comorbidity for treatment.

COURSE DIRECTOR: Dean D. Krahn, MD, Assistant Professor, Department of Psychiatry, Eating Disorders Program, University of Michigan Medical School

PRESIDING: **Doctor Krahn**

SPEAKERS:

Doctor Krahn

"The Relationship of Eating Disorders and Chemical Dependency: An Overview"

Blake Gosnell, PhD, Assistant Research Scientist, Department of Psychiatry and Director, Appetite Regulation, University of Michigan Medical School

"Relationship Between Diet Preference and Drug Use: Basic Studies"

Candace Kurth, RD, MS, Coordinator, Young Women's Health Behavior Survey

"The Epidemiology of Dieting and Drug Use in Michigan College Women"

Thomas Beresford, MD, Professor and Scientific Director, University of Michigan Alcohol Research Center

"Clinical Implications of the Comorbidity of Eating Disorders and Chemical Dependency"

Adolescent Sexuality Education

PRESENTED BY: Department of Obstetrics and Gynecology, University of Michigan Medical School

This course will give an overview of current medical issues facing adolescents in the 1990s. Experts in sexuality education will present the range of approaches currently being used in the era of sexually transmitted disease epidemics.

COURSE DIRECTOR: **Thomas E. Elkins, MD,** Chief, Division of Gynecology, University of Michigan Medical Center

PRESIDING: **Doctor Elkins**

SPEAKERS:

Doctor Elkins

Douglas E. Brown, BA, PhD, Associate Professor of Christian Doctrin, Harding Graduate School of Religion, Memphis, Tennessee

Marion Howard, PhD, Professor, Department of Obstetrics Gynecology and Director of Teen Services Program, Grady Memo Hospital, Atlanta, Georgia

Doreen Poupard, PhD, Assistant Superintendent for Curriculum Instruction, Ann Arbor Public Schools

Virginia Russell-Sheldon, Middle School Health Education, A Arbor Public Schools

Biomedical Ethics: Urban Health System Perspectives

PRESENTED BY: Henry Ford Health System and MSMS Commit on Biomedical Ethics

The course objective is to familiarize the attendee with several ma biomedical ethical issues affecting medical practice in urban hea system settings. Physician assisted suicide, minority issues in biome cal ethics, assessment of capacity to choose medical treatments, and update on the advanced directives implications will be discussed.

COURSE DIRECTOR: **John Popovich, Jr., MD,** Department Pulmonary Medicine, Henry Ford Hospital, Detroit and Henry Fc Health System

PRESIDING: **Doctor Popovich**

SPEAKERS:

Kathryn Moseley, MD, Senior Staff Physician, Department of Pe atrics, Henry Ford Health System, Detroit

"Minority Issues and Perspectives in Biomedical Ethics"

Richard Preisman, MD, Senior Staff Physician, Department of Ps chiatry, Henry Ford Health System, Detroit

"Assessment of Capacity to Choose Medical Treatment in Acute Ca Patients"

Mary Beth Tupper, MD, Senior Staff Physician, Department Geriatric Medicine, Henry Ford Health System, Detroit

"Advanced Directives in Michigan: A Geriatric Perspective"

Howard Brody, MD, Director, Center for Ethics and Humaniti Department of Family Practice, Michigan State University College Human Medicine and Chairman, MSMS Committee on Biomedic Ethics

"Physician Assisted Suicide: Questions for Professionals and t Public"

The Clinical Evaluation and Differentiation of the Dementias

PRESENTED BY: Michigan College for Nuclear Medicine Phy cians

This course will provide the primary care physician with information the demographics of the dementia problem, the clinical evaluation en for and differentiate dementia from depression and delu- al states, various methodologies available to determine the ific etiology of dementia in a given patient, and management.

URSE DIRECTOR: **John E. Freitas, MD,** Director, Positron gnostic Center, William Beaumont Hospital, Royal Oak

SIDING: **Doctor Freitas**

AKERS:

tor Freitas

aging Evaluation of Dementia"

hael Maddens, MD, Division Chief, Division of Gerontology, liam Beaumont Hospital, Royal Oak

inical Evaluation and Management of Dementia"

anagement of Lower Extremity juries in Sports

ESENTED BY: Michigan Orthopaedic Society and Orthopaedic gery Associates, P.C., Ypsilanti

s course will complement the morning's course on "The Team sician." Emphasis will be placed on current methodologies for naging various lower extremity injuries experienced as a result common sporting activities. The program will interest primary e physicians, orthopaedic surgeons, athletic trainers and others olved in sports medicine.

URSE DIRECTOR: **William M. Heston, MD,** Chairperson, gram Committee, Michigan Orthopaedic Society

ESIDING: **Waldomar M. Roeser,** MD, Orthopaedic Surgeon l Team Physician, Eastern Michigan University, Ypsilanti

EAKERS:

ctor Roeser

requently Missed Lower Extremity Injuries"

thy Susan, MS, RPT, Director, Center for Sports Medicine and ness, Ypsilanti

uidelines and Methods of Athlete Rehabilitation"

vid H. Janda, MD, Director, Institute for Preventative Sports dicine; Orthopaedic Surgeon, Catherine McCauley Health Cen- and University of Michigan Medical School

jury Prevention in Sports Medicine"

mes Holmes, MD, Orthopaedic Surgeon, Catherine McCauley alth Center and University of Michigan Medical Center

ommon Foot and Ankle Injuries"

anagement of The Post MI Patient

RESENTED BY: American Heart Association and Cardiac tensive Care Unit, Henry Ford Hospital, Detroit

The objective of this course is to provide physicians with a clear understanding of the use of various medications, diagnostic testing and cardiac rehabilitation for the post MI patient. The role of beta blockers and calcium channel blockers will be discussed.

COURSE DIRECTOR: **Mihai Gheorghiade, MD,** Chief, Cardiac Intensive Care Unit, Henry Ford Hospital, Detroit

PRESIDING: **Doctor Gheorghiade**

SPEAKERS:

Charles Webb, MD, Director, Cardiac Electrophysiology Laboratory, Henry Ford Hospital, Detroit

"The Management of Post Myocardial Infarction Arrhythmias"

Philip Kraft, MD, Senior Staff Physician, Cardiovascular Medicine, Henry Ford Hospital, Detroit

"The Role of PTCA in Post Myocardial Infarction Patients"

Stephen Smith, Senior Staff Physician, Division of Cardiovascular Medicine, Henry Ford Hospital, Detroit

"The Role of Betablockers and Counter Betablockers Post Myocardial Infarction"

Doctor Gheorghiade

"The Management of Acute Myocardial - The First 24 Hours"

The Resurgence of Childhood Diseases, and New Trends in Immunizations: Are Physicians Keeping Pace?

PRESENTED BY: Division of Infectious Diseases, Children's Hospital of Michigan, Detroit

This course will evaluate the resurgence of childhood diseases and will explore new trends in immunizations. Discussion will include Kawasaki Disease, the return of Group A Streptococci and Congenital Syphilis.

COURSE DIRECTOR: **Adnan S. Dajani, MD,** Professor, Department of Pediatrics, Children's Hospital of Michigan, Detroit

PRESIDING: **Doctor Dajani**

SPEAKERS:

Doctor Dajani

"Immunization Update"

Michelle Berry, MD, Assistant Professor, Department of Pediatrics, Children's Hospital of Michigan, Detroit

"Kawasaki Disease"

Doctor Dajani

"The Return of Group A Streptococci"

Doctor Berry

"The Return of Congenital Syphillis"

Selected Topics in Plastic Surgery

PRESENTED BY: Michigan Academy of Plastic Surgeons

A series of papers by the Wayne State University School of Medicine staff and residents will discuss Plastic Surgery topics under review. As in previous years, research interests will be correlated with clinical problems. This course is directed towards practicing Plastic Surgeons, Hand Surgeons and residents in training.

COURSE DIRECTOR: **Donald M. Ditmars, Jr., MD,** Division Head, Division of Plastic Surgery, Henry Ford Hospital, Detroit

PRESIDING: **Walter G. Sullivan, MD,** Chief, Division of Plastic and Reconstructive Surgery, Wayne State University School of Medicine

SPEAKERS:

Doctor Sullivan

"Current Treatment of Cleft Deformities"

Paul Ziedel, MD, Director, Hand Surgery Fellowship Program, Wayne State University School of Medicine

"Topics in Hand Surgery"

Doctor Sullivan

"Facial Fractures Treatment at Major Trauma Center"

Michelle Hardaway, MD, Director, Burn Unit, Detroit Receiving Hospital, Detroit

"Topics in Burn Care"

Michael Freedland, MD, General Surgery Resident, Wayne State University School of Medicine

"Biomechanical Studies of a New Dermal Substitute"

Philip Szwiakun, MD, General Surgery Resident, Wayne State University School of Medicine

"Revascularization and Resorption of Membranous vs. Endochondral Bone"

Richard J. Phillips, MD, Associate Director, Department of Pediatric Plastic Surgery, Children's Hospital of Michigan

"Current Treatment of Craniosynostosis"

Update on Gestational Diabetes Mellitus

PRESENTED BY: Michigan Section, American College of Obstetr and Gynecology

Gestational Diabetes Mellitus affects 3-5% of all pregnancies and h implications for fetal development, complications at delivery, morb ity in the newborn, childhood growth, and long term maternal morb ity. New developments will be reviewed including choice of screeni methods, self monitoring of glucose, indications for insulin thera and postpartum follow-up.

COURSE DIRECTOR: **Robert P. Lorenz, MD,** FACOG, Assoc tion Professor, Department of Obstetrics and Gynecology, Wayne St University School of Medicine; Director, Division of Maternal-Fe Medicine, William Beaumont Hospital, Royal Oak

PRESIDING: **Doctor Lorenz**

SPEAKERS:

Doctor Lorenz

"Gestational DM = So What? Implications for the Pregnancy a Beyond"

Sander J. Paul, MD, Medical Consultant, High Risk Pregnan Program, Division of Maternal-Fetal Medicine, William Beaumc Hospital, Royal Oak

Solomon I. Rosenblatt, MD, Clinical Assistant Professor, Departm of Internal Medicine, Wayne State University School of Medici Medical Consultant, High Risk Pregnancy Program, William Bea mont Hospital, Royal Oak

"Progress in Therapy with Diet and Exercise"

Chris T. Sloan, MD, FACOG, Assistant Director, Division of Mat nal-Fetal Medicine, William Beaumont Hospital, Royal Oak

"Recommendations for Screening Methods"

Doctor Lorenz

"Self Monitoring of Blood Glucose: Is It Necessary for GDM?"

Paul von Oeyen, MD, FACOG, Assistant Director, Division Maternal-Fetal Medicine, William Beaumont Hospital, Royal Oak

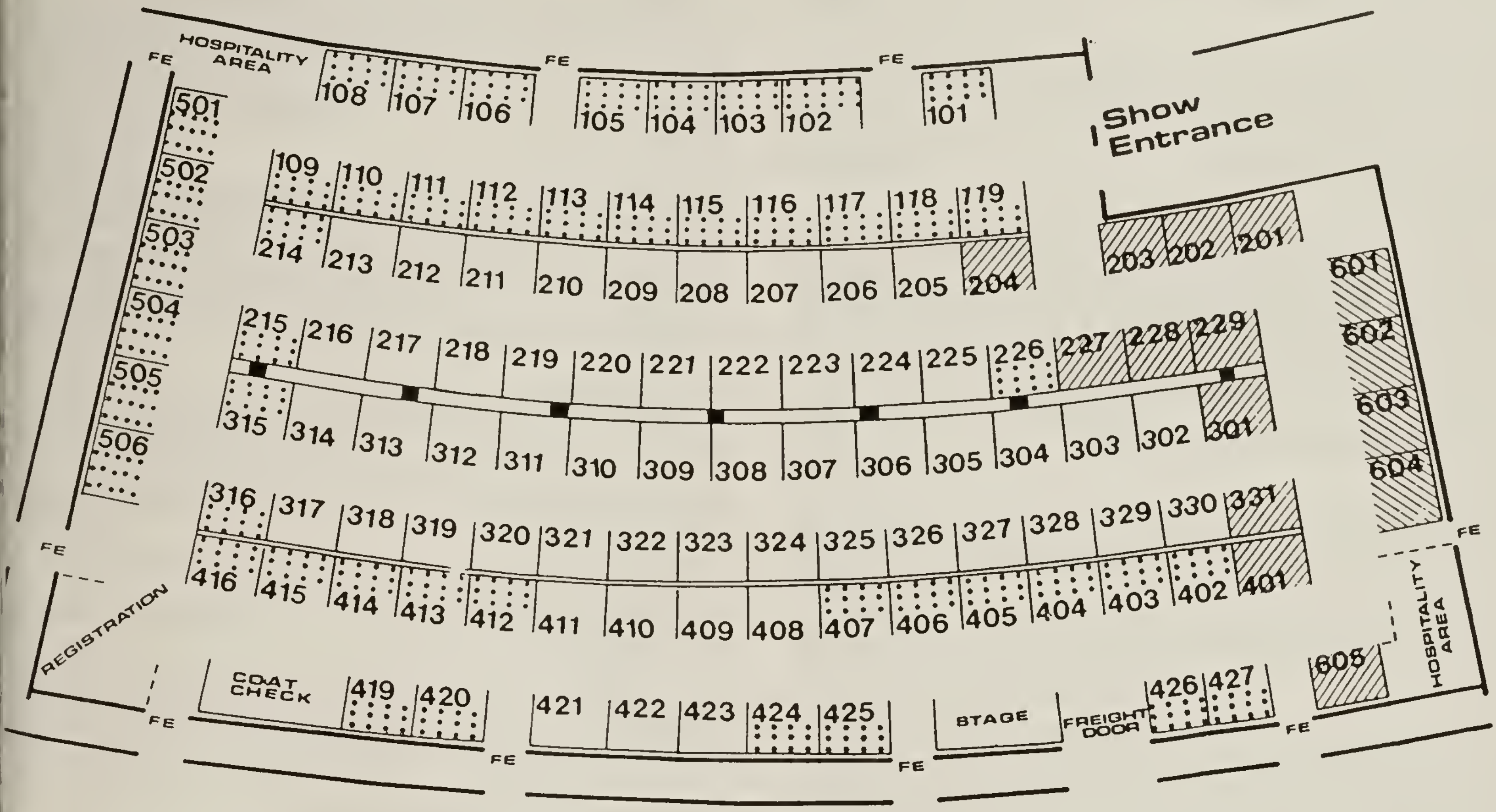
"The Role of Insulin Therapy - All? Some? Who?"

Doctor Rosenblatt

"Care of GDM After Delivery: Postpartum and Beyond"

All Courses Offer 3 Hours Each of Category I CME Credit.

eat Lakes Exhibit Center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HOSPITALITY AREA

xhibit Information

hibit Hours

esday, November 12

0 a.m. - 3:30 p.m .... Registration
d Exhibits Open to Physicians and Guests
mplimentary Exhibit Hall Passes Available

0 p.m. - 6:00 p.m .... Physician Reception
onsored by MSMS Endorsed Services;
ily Doorprize Winners Announced

ednesday, November 13

30 a.m. - 3:30 p.m .... Registration
d Exhibits Open to Physicians

0 p.m. - 6:00 p.m .... Physician Reception
onsored by 1991 Exhibitors;
ily Doorprize Winners Announced

hursday, November 14

:45 a.m. - 1:00 p.m. .... Networking Luncheon
onsored by Exhibitors, to be held in Hubbard Ballroom; Daily
oorprize Winners Announced

e Exhibit Center will not be open on Thursday. See page 3 for formation regarding locations for Registration and Coffee Service Thursday.

Coffee

Coffee will be available during the hours of the Exhibit Center, compliments of the Exhibitors and provided by the Michigan Society of Medical Assistants.

Dessert/Activities

A Deli lunch will be held from 11:45 a.m. - 1:00 p.m. in the Hubbard Ballroom on Tuesday and Wednesday. Dessert and coffee will be served in the Exhibit Center, and special activities will be presented on the Exhibit Center stage. A schedule of events will be provided with registration materials and will be announced at each day's luncheon.

Thursday's Networking Luncheon will be a full service meal, held in the Hubbard Ballroom. Special activities will be presented and Daily Doorprize Winners announced during the luncheon.

Receptions

Refreshments will be served during Tuesday and Wednesday's Physician Receptions held in the Great Lakes Exhibit Center. Daily Doorprize Winners also will be announced.

These Exhibitors at Your Service

Advance Medical/Metpath **Booth 118**
444 Giddings Road
Auburn Hills, MI 48326
Clinical reference laboratory service. Learn about the latest in specimen handling and entry and the latest advances in laboratory testing.

American Rehabilitation Network **Booth 313**
14799 Dix Toledo
Southgate, MI 48192
Our singular focus is to provide quality outpatient rehabilitation care to patients with diagnoses requiring physical rehabilitation. This focus allows us to tailor programs to meet the needs of the patient and referring physicians. Orthopaedic services, neurological outpatient services, pain management program and work hardening program are available at our Macomb Institute and Downriver Institute, and Orthopaedic Services at our newest location the Beaconsfield Center in East Detroit.

Association Members Retirement Program **Booth 604**
200 Plaza Drive
Secaucus, NJ 07096
The MSMS-Association Members Retirement Program offers you flexibility, time-saving service and a choice of professionally managed investment options to suit your retirement needs.

Battle Creek Health System **Booth 420**
183 West Street
Battle Creek, MI 49016
Battle Creek Health System, a center for healthcare excellence in southwest Michigan, including 400 beds, offers exceptional practice, obstetrics/gynecology, pediatrics, emergency medicine and neurology invites discussion by physicians seeking a new affiliation.

Bell Atlantic TriCon Leasing, Medical Finance **Booth 603**
6565 West Loop South, Suite 120
Bellaire, TX 77401
MSMS endorsed medical equipment leasing program provides financing/leasing for any medical, surgical, office or computer equipment used in a medical practice.

Bennethum Computer Systems **Booth 102**
7125 Orchard Lake Road, Suite 310
West Bloomfield, MI 48322
In business since 1968, we are the oldest company in Michigan providing in-office medical systems. With two different programs we can better meet your needs and price range.

Bernie Hoffmann Associates, Inc **Booth 330**
15565 Northland Drive, Suite 800 East
Southfield, MI 48075-5371

BFI Medical Waste Systems **Booth 416**
1301 E. Alexis Road
Toledo, OH 43612

Blue Cross Blue Shield-Automated Input **Booth 105**
53200 Grand River
New Hudson, MI 48165
Celebrating its 20th Anniversary in 1991, BCBSM's Automated Input Department is proud of its time proven contribution to Quality Customer Service. Automated Input provides and supports the electronic (paperless) submission of claims for both BCBSM and Medicare B.

Blue Cross Blue Shield of Michigan **Booth 501**
53200 Grand River Avenue - Dept. L821
New Hudson, MI 48165-9801

Blue Cross Blue Shield of Michigan **Booth 216**
600 Lafayette East, Mail Code 1415
Detroit, MI 48226
A Blue Cross Blue Shield of Michigan - Medicare Professional Relations Representa
will be available to discuss Part B Medicare issues - to include concerns regarding c
flow, billing, current and upcoming program changes.

Blue Cross Blue Shield - Professional Provider Systems **Booth 1**
53200 Grand River
New Hudson, MI 48165
The Professional Provider Systems Department of Blue Cross/Blue Shield of Michi
is dedicated to providing quality services and products to the health care professi
Three software programs provide electronic claim submission for Blue Cross/B
Shield, Medicare, and Medicaid. Automate all or part of your business.

Boehringer Ingelheim Pharmaceuticals, Inc **Booth 2**
P.O. Box 368
Ridgefield, CT 06877
Product line we will display will be: Atrovent; TTS; Mexitic; Buspar; Alupent
Activasp.

CBC Laboratory Service **Booth 2**
2740 28th Street, S.W.
Grand Rapids, MI 49509

CRT Management Company **Booth 42**
6934 W. Fort Street
Detroit, MI 48209

Cellular One **Booth 2**
31500 Northwestern, #300
Farmington Hills, MI 48334
We will be displaying cellular products and pagers.

Colonial Valley Software, Inc **Booth 21**
3398 South Dye Road
Flint, MI 49507
Colonial Valley Software (CVS) markets a complete turnkey computer system tha
superior because of its telecommunications for faster payments, patient recall abil
excellent support, easy to use, and complete financial reporting. It is the discriminat
doctor's choice.

Comerica **Booth 20**
188 N. Woodward
Birmingham, MI 48009
Comerica offers high quality personal and professional financial services to meet y
financial needs. Your relationship manager will draw upon the resources of a $12 billi
financial institution to serve your borrowing or investment needs.

Comfort Care **Booth 40**
5409 Perry Drive
Waterford, MI 48329

Critical Care America **Booth 50**
1000 N. Opdyke Road, Suite F
Auburn Hills, MI 48326
Critical Care America (CCA) is a nationwide organization widely regarded as
industry leader in identifying and introducing innovative alternatives to traditio
hospital-based health care. Our company is firmly rooted in a tradition of medi
innovation and excellence.

Damon Clinical Laboratory **Booth 11**
4201 St. Antoine
Detroit, MI 48201
Damon Clinical Laboratories at the Detroit Medical Center will display our physici
teleprinters and CRT phone modems. These are convenient methods for retrieval
clinical laboratory results.

Davis-Smith Medical, Inc **Booth 50**
24725 W. 12 Mile Road, #302
Southfield, MI 48124

E lished in 1946, Davis-Smith is a full service Human Resources firm providing se ces to the medical profession in physician recruitment, administrative, clerical and cl cal placement, temporary personnel and consulting.

D rborn Regional Clinical Laboratories **Booth 505**
2 5 Merriman, Suite 1321
tland, MI 48185
D L is a CAP-accredited, federally licensed, full service laboratory with experience e mpassing nursing homes, physician offices, clinics and hospitals. Our dedicated p essional staff is supported by a renown team of pathologists and PhD scientists.

ability Determination Service - Education **Booth 317**
P Box 30011
L sing, MI 48909
T exhibit is for the purpose of acquainting physicians with the Social Security ibility Program. We dispense pertinent handouts which will be helpful in evaluation o sabled patients who may meet governmental requirements for disability benefits.

Pont Pharmaceuticals **Booth 224**
4 W. Webster
F al Oak, MI 48073

F ons Pharmaceuticals **Booth 208**
4 8 Amherst
F al Oak, MI 48073
F ons will be featuring Intal, comprehensive foundation asthma therapy as advocated t he NHLBI as well as, Nasalcrom, Delsym, Tussionex, Acarosan, Gastrocrom, F iapred and Americaine Otic. Please stop by for information, literature and patient cation materials.

kuda Denshi America Corporation **Booth 427**
2-180th Avenue N.E., Suite A-101
lmond, WA 98052

ixo, Incorporated **Booth 117**
21 Moon Lake Boulevard, Suite 204
fman Estates, IL 60194
rmaceuticals used in the treatment of acid/peptic disorders, hypertension, nchospastic diseases, allergic rhinitis and infectious diseases.

althCare Communications, Incorporated **Booth 221**
39 Sonoma Vista Drive
diMac™ Office Management software for the Apple Macintosh Computer. Functions ude: Patient and insurance billing, electronic claims submissions, accounts eivable tracking, patient records, and management reporting.

althPlus of Michigan **Booth 423**
50 S. Linden
). Box 1700
nt, MI 49501-1700

enry Ford Health System **Booth 406 & 407**
)0 Fisher Building
etroit, MI 48202-3012

. System, Incorporated **Booth 602**
4 East Highway 96
Paul, MN 55127
ull service collection agency endorsed by Physicians Service Group to all members the Michigan State Medical Society. All collection efforts are legal, ethical and as mprehensive as you want them to be.

nssen Pharmaceutica **Booth 410**
78 Timber Ridge Trail
arkston, MI 48346

MSE, Incorporated **Booth 314**
28530 Orchard Lake Road, #104
Farmington Hills, MI 48334

Marion Merrell Dow, Incorporated **Booth 211**
6309 West H Avenue
Kalamazoo, MI 49009

Mead Johnson Pharmaceuticals **Booth 108**
2400 W. Lloyd Expressway, B413
Evansville, IN 47721
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: BuSpar, Desyrel, Duricef, Monopril.

Medical Automation, Incorporated **Booth 425**
30400 Telegraph, Suite 383
Birmingham, MI 48010

Medical Billing Service **Booth 227 & 228**
29299 Franklin Road
Southfield, MI 48034
A computer service that is on-line to a computer center eliminating the need for an office to purchase a computer. Electronic claims processing.

Medical Software Solutions, Incorporated **Booth 107**
21800 W. Ten Mile, #214
Southfield, MI 48075
Medical Software Solutions (MSS) markets a comprehensive computer system solely to physicians' offices. MSS is a Michigan based firm providing "A practice management system backed by a caring, knowledgeable and innovative programming and customer support team."

Metro Rehabilitation Services, Incorporated **Booth 109**
4245 W. 14 Mile Road
Royal Oak, MI 48073
Outpatient physical therapy, sportscare, backcare clinics in Royal Oak, Dearborn, Utica and Roseville. Order same day appointments for your patient. Cybex, Extremity and Back testing available. Blue Cross and most insurances accepted.

Metrostaff Home Health Care **Booth 104**
28500 Southfield
Lathrup Village, MI 48076

Michigan Bell **Booth 502 & 503**
34115 W. 12 Mile, Suite 170
Farmington Hills, MI 48331
Michigan Bell offers a full spectrum of innovative services and seminars to help meet the unique communications needs of health care professionals.

Michigan Physicians Mutual Liability Company **Booth 203**
P.O. Box 1471
East Lansing, MI 48826
Michigan Physicians Mutual Liability Company presents a brief view of the company's commitment, experience and success in handling claims. Featured are the people behind the service — claims committee, staff and defense attorneys.

National Health Laboratories, Incorporated **Booth 213**
13250 Northend
Oak Park, MI 48237
A nationwide leader in clinical laboratory services with a full service laboratory located in Oak Park, Michigan. On site capabilities for Cytology, Pathology, Toxicology/G.C.M.S., plus a new regional Esoteric testing facility are highlights. Comprehensive billing capabilities and a preferred provider of many HMO plans.

Navy Recruiting District Michigan **Booth 309**
3100 E. Jefferson Avenue
Detroit, MI 48207-4221

Physician Service Group, Inc **Booth 601**
120 W. Saginaw Street
East Lansing, MI 48823
Helping physicians manage their practices. Physician Service Group, Inc. (PSG) is a subsidiary of the Michigan State Medical Society and was created to provide services for physicians. From personal and professional financial management assistance, individual practice evaluations, medical billing services, health and dental insurance programs to association administrative services, PSG offers top of the line products and services to help physicians.

PAC-COMP **Booth 419**
2888 East Long Lake, #102
Troy, MI 48098

PB Diagnostics **Booth 212**
151 University Avenue
Westwood, MA 02090

P.C. Medical Management, Incorporated **Booth 315**
25321 Five Mile Road, Suite 4
Redford, MI 48239
The areas of expertise that we specialize in, but are limited to, are as follows: Physicians Office Lab Systems; Supplies/Reagents; Laboratory Testing Equipment; Referral of Qualifies Lab Technologists; Complete Clinical Laboratory Services; EKG - Spirometer Equipment; Holter - T.T.E.M. Monitoring Systems; General Ultra-sound, ECHO Doppler Systems; Pain Management; Pharmaceutical Dispensing Systems; Radiology Consulting Services; Customized Medical Billing and Practice Management Systems and EMG Biofeedback Systems.

Parke-Davis **Booth 422**
651 Timberline Drive
Rochester Hills, MI 48063
We invite you to visit the Parke-Davis Booth where our Sales Representatives welcome the opportunity to discuss with you our product, Lopid. We hope you will join us.

Physicians Insurance Company of Michigan **Booth 103**
4295 Okemos Road
Okemos, MI 48864-2510
PICOM is a Michigan based, physician owned medical malpractice insurer servicing individual and group practices throughout Michigan. Deductible credits, merit rating and million dollar coverage available.

Physicians Total Care **Booth 214**
4095 Hulett Road
Okemos, MI 48864
Physicians Total Care of Michigan presents...PTC 9000 medication management system designed to meet the needs of the rapidly growing in-office physician pharmaceutical dispensing service.

POLCI **Booth 223**
4835 Towne Centre, Suite 201
Saginaw, MI 48604
Medical Billing Systems - Complete Medical Data Management for physicians, clinics, and out-patient facilities, including tape-to-tape or hardcopy billing, appointments and a comprehensive system of report documentation.

Preferred Laboratories **Booth 302**
1270 Doris Road
Auburn Hills, MI 48326
Preferred Laboratories is a leading Michigan owned, pathologist directed, CAP accredited, full service medical laboratory emphasizing quality and client service and specialized professional office laboratory consulting services for physicians.

Professional Alliance, Incorporated **Booth 3**
43512 Mound Road, Suite C
Sterling Heights, MI 48314

Professional Asset Management, Incorporated **Booth 2**
29829 Telegraph Road, L-100
Southfield, MI 48034
We are a member of the National Association of Security Dealers and Securit
Investors Protection Corporation specializing in Tax Advantaged Investments.
addition, we market a full line of stocks, bonds, mutual funds, tax shelters, IRA's,
Keoghs. We will be happy to answer any questions you may have.

Professional Health Care Forms **Booth 21**
by Specialty Business Forms
P.O. Box 49
Kalamazoo, MI 49005
Complete line of forms for Health Care including Blue Cross/Blue Shield Health C
Claim Forms, HCFA 1500, UB 82's, Statements for Various Systems, Encounter a
Stock Forms for Computer, Laser Printers and Typewriters. Continuous, laser sheet
and roll transcription labels.

Professional Practice Sales **Booth 31**
27208 Southfield Road
Lathrup Village, MI 48076
We can help you evaluate, market, transfer or start your private practice. While ma
may need to move on or sell out, others need to expand or merge. Let's talk about yo
future.

Retirement Plan Consulting Group **Booth 22**
373 S. Woodward
Birmingham, MI 48009
Well known retirement plan consultant Gerald J. LeVan will share his expertise on ho
physicians can obtain superior risk-adjusted rates of return for their pension, pro
sharing, Keogh, and IRA rollovers.

Roche Laboratories **Booth 11**
340 Kingsland Street
Nutley, NJ 07110

Saber-Salisbury and Associates **Booth 305**
25505 W. 12 Mile Road, Suite 4500
Southfield, MI 48034
Saber-Salisbury and Associates, Incorporated is a search firm with over 14 yea
experience specializing in meeting the diverse needs of healthcare facilities nationwid
We conduct customized searches in a personal, results-oriented manner.

Sandoz Pharmaceuticals **Booth 402**
59 Route 10
East Hanover, NJ 07936

Schering Corporation **Booth 303**
7218 Franklin Road
Birmingham, MI 48010
Proventil® Family of Products, for asthma - Provential Repetabs®, Proventil® Inhalers
Proventil® Solution, Proventil® Symptoms, Vancenare® Aq. for allergic rhinitix Vanceril
inhaler for topical anti-inflammatory inhaled. Intion-A® for Hapatis NA/NB/C.

Scientific Data Management, Incorporated **Booth 312**
23885 Denton
Mt. Clemens, MI 48043

Scholnick Associates, Incorporated **Booth 424**
30150 Telegraph Road, #167
Birmingham, MI 48010

hibitors *continued*

h Kline Beecham Pharmaceuticals **Booth 110**
'ictors Way, Suite 200
rbor, MI 48108
sentatives will be on hand to answer your specific questions and to provide nation on our products and services.

ialty Pathology Laboratory, Incorporated **Booth 319**
0 Woodward Avenue
ant Ridge, MI 48069

bb U.S. Pharmaceutical Group **Booth 308**
Box 4500
eton, NJ 08543
ob has long been a leader in the development of therapeutic and diagnostic ucts for the prevention, detection and treatment of diseases. You are cordially d to meet our representatives who will be available at our exhibit to discuss our ne of health care products.

mit Pharmaceuticals **Booth 112**
Joshua Drive
, MI 48098
nsin® - Ace inhibition without age inhibition. Transderm-Nitro® - Convenient te therapy. Actigall® - Oral dissolution therapy for noncalcified gallstones.

versal Standards Medical Laboratories **Booth 106**
)5 Evergreen
hfield, MI 48075

U.S. Army Medical Department **Booth 316**
5111 Leesburg Pike, Suite 63B
Falls Church, VA 22041-3258

Versyss Incorporations **Booth 409**
2360 S. Linden Road
Flint, MI 48532

Wolverine X-Ray Sales and Services **Booth 421**
24655 Grand River Avenue
Detroit, MI 48219

Wyeth-Ayerst Laboratories **Booth 206**
400 Liddy Drive
Brighton, MI 48116
Please visit the Wyeth-Ayerst Laboratories exhibit and our representatives will be happy to discuss Premarin, Triphasil, Vereian and Orudis.

The Michigan State Medical Society is pleased to provide space at the Annual Scientific Meeting for the exhibitions. The Society does not thereby endorse or recommend the service and products of the exhibitor or in any way pass upon their merits.

dex to Exhibitors

TH	
	Bennethum Computer Systems
	Physicians Insurance Company of Michigan
	Metrostaff Home Health Care
	Blue Cross Blue Shield - Automated Input
	Universal Standards Medical Laboratories
	Medical Software Solutions, Incorporated
	Mead Johnson Pharmaceuticals
	Metro Rehabilitation Services, Incorporated
	Smith Kline Beecham Pharmaceuticals
	Roche Laboratories
	Summit Pharmaceuticals
	Blue Cross Blue Shield - Professional Provider Systems
	Damon Clinical laboratory
	Glaxo, Incorporated
3	Advance Medical/Metpath
1	Comerica
2	Cellular One
3	Michigan Physicians Mutual Liability Company
5	Boehringer Ingelheim Pharmaceuticals, Incorporated
6	Wyeth-Ayerst Laboratories
7	Professional Asset Management, Incorporated
8	Fisons Pharmaceuticals
1	Marion Merrell Dow, Incorporated
2	PB Diagnostics
3	National Health Laboratories, Incorporated

BOOTH	
214	Physicians Total Care
215	CBC Laboratory Service
216	Blue Cross Blue Shield
217	Colonial Valley Software, Incorporated
218	Professional Health Care Forms
221	HealthCare Communications, Incorporated
223	POLCI
224	DuPont Pharmaceuticals
225	Retirement Plan Consulting Group
227	Medical Billing Service
228	Medical Billing Service
229	Randolph Medical
302	Preferred Laboratories
303	Schering Corporation
305	Saber-Salisbury and Associates
308	Squibb U.S. Pharmaceutical Group
309	Navy Recruiting District Michigan
312	Scientific Data Management, Incorporated
313	American Rehabilitation Network
314	MSE, Incorporated
315	P.C. Medical Management, Incorporated
316	U.S. Army Medical Department
317	Disability Determination Service - Education
318	Professional Practice Sales
319	Specialty Pathology Laboratory, Incorporated
329	Professional Alliance, Incorporated

BOOTH	
330	Bernie Hoffman Associates, Incorporated
402	Sandoz Pharmaceuticals
406	Henry Ford Health System
407	Henry Ford Health System
408	Comfort Care
409	Versyss Incorporation
410	Janssen Pharmaceutica
416	BFI Medical Waste Systems
419	PAC-COMP
420	Battle Creek Health System
421	Wolverine X-Ray Sales and Services
422	Parke-Davis
423	HealthPlus of Michigan
424	Scholnik Associates, Incorporated
425	Medical Automation, Incorporated
426	CRT Management Company
427	Fukuda Denshi America Corporation
501	Blue Cross Blue Shield
502	Michigan Bell
503	Michigan Bell
504	Critical Care America
505	Dearborn Regional Clinical Laboratories
506	Davis-Smith Medical, Incorporated
601	Physician Service Group, Incorporated
602	I.C. Systems, Incorporated
603	Bell Atlantic TriCon Leasing, Medical Finance
604	Association Members Retirement Program

MSMS extends its appreciation to these exhibitors for their financial contribution to the meeting. NEW THIS YEAR, exhibitors may conduct daily door prize drawings to encourage physicians to visit their booth. A complete listing of exhibitors and their door prizes will be included in your registration materials.

Schedule of Special Events

Monday, November 11, 1991

Accent Reduction Seminar

Monday, November 11 at 6:00 p.m.
Stearns Knight Suite (2nd floor)
This seminar is for International Medical Graduates who want to improve communication with their patients.
Contact: Ms. Betty McNerney, MSMS

Tuesday, November 12, 1991

MSMS Office Financial Management Seminar

Tuesday, November 12 at 8:30 a.m.
Marquis Ballroom (2nd floor)
Course fee includes deli lunch and admission to exhibit hall.
Contact: MSMS Office of Physician Education

MSMS ASM Planning Committee Reception

Tuesday, November 12 at 6:00 p.m.
Contact: Ms. Lori Randall, MSMS

Wednesday, November 13, 1991

FREE "Early Bird" Plenary Session

"Substance Abuse: The Physician's Role"
Charles C. Vincent, MD, Detroit
Wednesday, November 13 at 7:00 a.m.
Hubbard Ballroom
Coffee and Rolls included.
See page 11 for course description.

MSMS Committee on Concerns of Women Physicians

Luncheon
Wednesday, November 13 at 11:30 a.m.
Rolls Royce Suite (2nd floor)
Open to all women physicians. $15 Lunch Ticket required.
Contact: Ms. Lori Randall, MSMS

MSMS Committee of Specialty Society Presidents

Luncheon
Wednesday, November 13 at 12:00 noon
Franklin Room (2nd floor)
Sponsored by Michigan Physicians Mutual Liability Company
Contact: Mr. Dave Fox, MSMS

Michigan Occupational Medical Association

Board Meeting/Lunch
Wednesday, November 13 at 12:00 noon
Thomas Room (2nd floor)
Reception/Dinner at 6:00 p.m.
Houston/San Francisco, Regency Ballroom
Contact: John J. Bernick, MD

Michigan Orthopaedic Society

Board Meeting, Wednesday, November 13 at 3:00 p.m.
Franklin Room (2nd floor)
Reception/Dinner at 6:00 p.m.
Atlanta/Chicago, Regency Ballroom
Contact: Ms. Joanne Sackett

Michigan Society of General Surgeons

Reception/Dinner, Wednesday, November 13 at 5:00 p.m.
Cord Room (2nd floor)
Contact: Caroline Kimmel, MSMS

Wayne State University Medical Alumni Associati

Reception
Wednesday, November 13 at 6:00 p.m.
Stearns Knight Suite (2nd floor)
Contact: Ms. Bunny Leach

Thursday, November 14, 1991

FREE "Early Bird" Plenary Session

"Genetics as the Basis for Medicine in the 21st Century"
Francis S. Collins, MD, PhD, Ann Arbor
Thursday, November 14 at 7:00 a.m.
Hubbard Ballroom
Coffee and Rolls included.
See page 17 for course description.

Michigan Academy of Physical Medicine and Rehabilitation

Reception
Thursday, November 14 at 6:00 p.m.
Stearns Knight Suite (2nd floor)

Michigan Academy of Plastic Surgeons

Reception/Dinner
Thursday, November 14 at 6:00 p.m.
Rolls Royce Suite (2nd floor)
Contact: Donald M. Ditmars, Jr. MD

Michigan College of Nuclear Medicine Physicians

Reception/Dinner/Meeting
Thursday, November 14 at 6:00 p.m.
New York/Washington, Regency Ballroom
Contact: John E. Freitas, MD

Please check Hyatt daily events monitor, as room assignments may change.

ndex to Course Directors and Instructors

AG NAME
1 ...... Gaylord D. Alexander, MD, Detroit
4 ...... John A. Anderson, MD, Detroit
3 ...... Keith Apelgren, MD, East Lansing
9 ...... Elizabeth Arnold, MD, Detroit
3, ... Regine Aronow, MD, Detroit
3 ...... Ed Auston, MD, East Lansing
3 ...... James Babel, MD, East Lansing
4 ...... Janice Bach, MS, Lansing
6 ...... Beth Bacon
7 6 . Greg Baker, East Lansing
7 ...... Frank Bagnsco, MD, Pontiac
9 ...... Donald H. Batts, MD, Kalamazoo
4 ...... Erawati V. Bawle, MD, Detroit
6 .... R. Beale, MD, Detroit
3 ...... Wesley Beemer, MD, Ypsilanti
6 ...... Donald Bentsen
0 .... Thomas Beresford, MD, Ann Arbor
6 ...... John J. Bernick, MD, Dearborn
1 .... Michelle Berry, MD, Detroit
1 .... Bert Bez, DO, Lansing
7 .... Charla M. Blacker, MD, Detroit
6 .... Jason Bodzin, MD, Detroit
0 .... Henry Bone, MD, Detroit
9 .... Ray A. Breitenbach, MD, MS, Detroit
0, ... Howard Brody, MD, East Lansing
0 .... Douglas E. Brown, BA, PhD, Memphis, TN
9 .... David A. Burks, Detroit
7 .... Gary Chodoroff, MD, Detroit
7 2, 6 Glena Christiansen, Lansing
2 .... Robert E. Cilley, MD, Ann Arbor
7 .... Francis S. Collins, MD, PhD, Detroit
7 .... Brian Cook, MD, Monroe
2 .... Arnold G. Coran, MD, Ann Arbor
7 .... Lawrence Crane, MD, Detroit
.... Charles Cubbage, MD, Lansing
.... George Curtis, MD, Ann Arbor
.... Adnan S. Dajani, MD, Detroit
.... Miriam S. Daly, MD, Albion
.... Davis S. Davenport, MD, Kalamazoo
.... Glenn Davis, MD, Detroit
2, 6 Debra Deford, RN, Lansing
.... Phil Dennis, MD, East Lansing
.... Bruce Deshere, MD, Detroit
.... F. G. Diaz, MD, PhD, Detroit
.... James Dillan, MD, Ann Arbor
17 .... Donald M. Ditmars, Jr., MD, Detroit
.... Gloria Edwards, PhD, Ann Arbor
.... Thomas E. Elkins, MD, Ann Arbor
.... Mark I. Evans, MD, Detroit
.... J. David Fachnie, MD, Detroit
.... Evelyn J. Fisher, MD, Detroit
.... Caleb Fleming, MD, Detroit
.... James G. Fordyce, MD, Dearborn
.... Michael Freedland, MD, Detroit
.... Atis Freimanis, MD, East Lansing
14 .... John E. Freitas, MD, Royal Oak
.... David Fukazawa, New Detroit
.... William Ganz, MD, Detroit
.... Mihai Gheorghiade, MD, Detroit
.... David Gift, MD, East Lansing
.... Kenneth A. Ginsburg, MD, Detroit
.... Blake Gosnell, PhD, Ann Arbor
.... Alexander Gottschalk, MD, East Lansing
.... Martha L. Gray, MD, Ann Arbor
.... Kenneth E. Greer, MD, Charlottesville, VA
.... Steven D. Ham, DO, Detroit
.... Michelle Hardaway, MD, Detroit
.... Charles E. Harmon, Lansing
.... Roger F. Haskett, MD, Ann Arbor
.... Houri Hassouna, MD, East Lansing
.... Maria F. Hayes, MD, Dearborn

PAGE NAME
15 .... Ray E. Helfer, MD, East Lansing
21, 19 .... William M. Heston, MD, Ypsilanti
13 .... Ronald B. Hirschl, MD, Ann Arbor
21 .... James Holmes, MD, Ann Arbor
9 .... Wolfgang Holzgreve, MD, Munster, Germany
20 .... Marion Howard, PhD, Atlanti, GA
6 .... Beth Hummer, MD, Detroit
17 .... Paul H. Izenberg, MD, Ypsilanti
10 .... Kenneth Jamerson, MD, Ann Arbor
21, 19 .... David H. Janda, MD, Ann Arbor
16 .... Richard Jaszewski, MD, Allen Park
17 .... Glen W. Jelks, MD, New York, NY
9 .... Mark P. Johnson, MD, Detroit
12 .... Mark W. Johnson, MD, Ann Arbor
15, 12 .... Timothy Johnson, MD, Ann Arbor
16 .... Evelyn K. Jones, Lansing
8 .... Dorothy M. Kahkonen, MD, Detroit
6 .... Angelos Kambouris, MD, Detroit
9 .... Aaron Kirkemo, MD, Detroit
10 .... Dana Kissner, MD, Detroit
10 .... George A. Kling, MD, Detroit
21 .... Philip Kraft, MD, Detroit
20 .... Dean D. Krahn, MD, Ann Arbor
19 .... James Krause, MD, Detroit
20 .... Candace Kurth, RD, MS, Ann Arbor
17 .... Richard M. Lampman, PhD, Ann Arbor
17, 12, 6 Laura Lane, RN, Lansing
17 .... Michael Leither, PT, Redford
17 .... Nicholas J. Lekas, MD, Detroit
22 .... Robert P. Lorenz, MD, Royal Oak
16 .... John M. MacKeigan, MD, Grand Rapids
19 .... Derek Mackesey, MD, CMO, Canada
21 .... Michael Maddens, MD, Royal Oak
15 .... Stuart Maddin, MD, Vancouvar, BC
10 .... Beatrice Madrazo, MD, Royal Oak
7 .... David M. Magyar, DO, Dearborn
9 .... David B. Martin, MD, Traverse City
8 .... John R. Maurer, MD, Grand Rapids
8 .... Daniel McCoy, PhD, Grand Rapids
17 .... Douglas McDonald, MD, Oxford
16 .... Daniel McNeil, MD, Holland
7 .... Mark A. McQuillan, MD, Ann Arbor
17, 12, 6 Anthony Meholic, RN, Lansing
14 .... Donald A. Meier, MD, Troy
12 .... Curtiz D. Meriwether, MD, Detroit
9 .... Edward Messing, MD, Madison, WI
16 .... Cleon Michael, MD, Ann Arbor
14 .... Orlando J. Miller, MD, Detroit
20 .... Kathryn Moseley, MD, Detroit
12 .... Christine Nelson, MD, Ann Arbor
16 .... Robert Niccolini, MD, Detroit
17 .... Daniel Nolan, PhD, Ann Arbor
16 .... James G. O'Brien, MD, East Lansing
6 .... Robert O'Bryan, MD, Detroit
14 .... John L. Ohman, Jr., MD, Boston, MA
16 .... Steven E. Olchowski, MD, St. Clair Shores
17, 12, 6 Robert K. Orr, Jr., DO, Lansing
8 .... Carl E. Orringer, MD, Ann Arbor
12 .... Enrique M. Ostrea, Jr., MD, Detroit
19 .... B. Babu Paidipaty, MD, Livonia
16 .... Che Song Park, MD, East Lansing
7 .... Karitkumar Patel, MD, Pontiac
22 .... Sander J. Paul, MD, Royal Oak
9 .... James O. Peabody, MD, Detroit
16 .... Rene Peleman, MD, Ann Arbor
9 .... John A. Penner, MD, East Lansing
15 .... Joseph Pernicone, DO, PhD, East Lansing
8 .... Patti Peterson, MD, Detroit
16 .... Anthony Petrilli, MD, East Lansing
22 .... Richard J. Phillips, MD, Detroit

PAGE NAME
12 .... Theodore Z. Polley, Jr., MD, Ann Arbor
20 .... John Popovich, Jr., MD, Detroit
15 .... E. James Potchen, MD, East Lansing
20 .... Doreen Poupard, PhD, Ann Arbor
20 .... Richard Preisman, MD, Detroit
6 .... U. Raju, MD, Detroit
10 .... K. P. Ravikrishnan, MD, Royal Oak
6 .... Murray Rebner, MD, Detroit
13 .... Donald Reed, MD, East Lansing
17 .... Kenneth Richter, DO, Southfield
15 .... O. G. Rodman, MD, Detroit
21, 19 .... Waldomar M. Roeser, MD, Ypsilanti
22 .... Solomon I. Rosenblatt, MD, Royal Oak
7 .... Mark Rosner, MD, Detroit
10 .... David R. Rovner, MD, East Lansing
20 .... Virginia Russell-Sheldon, Ann Arbor
13 .... Harold Sauer, MD, East Lansing
11 .... Charles Schmitter, MD, Ypsilanti
18 .... David E. Schteingart, MD, Ann Arbor
9 .... Paula Schuman, MD, Detroit
17 .... Michael L. Schwartz, MD, Detroit
14 .... Charles R. Scriver, MD, Montreal, Canada
10 .... Mark Segel, MD, Detroit
10 .... Brahm Shapiro, MD, Ann Arbor
9 .... S. D. Shetty, MD, Detroit
15 .... Arlene Sierra, MPA, East Lansing
6 .... Allan Silbergleit, MD, Pontiac
7 .... Larry Silverman, MD, Birmingham
11 .... Steven Slack, MD, Ypsilanti
22 .... Chris T. Sloan, MD, Royal Oak
15 .... Carol Slomski, MD, East Lansing
21 .... Stephen Smith, Detorit
13 .... Robert Soderstrom, MD, Flint
12 .... H. Kaz Soong, MD, Ann Arbor
10 .... Renate Soulen, MD, Detroit
10 .... James Sowers, MD, Detroit
10 .... Susan Steigerwalt, MD, Detroit
7 .... Laurence Stephenson, MD, Detroit
11 .... Georgine M. Steude, MD, Ann Arbor
16 .... John F. Strandmark, MD, Lansing
22 .... Walter G. Sullivan, MD, Detroit
21 .... Cathy Susan, MS, RPT, Ypsilanti
15 .... G. Marie Swanson, PhD, East Lansing
22 .... Philip Szwiakun, MD, Detroit
14 .... Gary B. Talpos, MD, Detroit
14 .... Charles I. Taylor, MD, West Bloomfield
13 .... Barbara Threatt, MD, Ann Arbor
14 .... Alkis G. Togias, MD, Baltimore, MD
17 .... Judy Tomer, RN, Ann Arbor
8 .... John Trestrail, RPH, Grand Rapids
12 .... Jonathan D. Trobe, MD, Ann Arbor
7 .... Dianne Trudell, MD, Flint
20 .... Mary Beth Tupper, MD, Detroit
16 .... Hollis Turnham, Lansing
12, 11 .... Charles C. Vincent, MD, Detroit
22 .... Paul vonOeyen, MD, Royal Oak
17 .... Alexander Walt, MB, ChB, Detroit
7 .... Bradford L. Walters, MD, Detroit
12 .... James N. Wardell, MD, Detroit
15 .... David Wartinger, DO, East Lansing
21 .... Charles Webb, MD, Detroit
7 .... Joseph J. Weiss, MD, Livonia
16 .... Helen Wentz, Lansing
13 .... Janice L. Werbinski, MD, Kalamazoo
11 .... Niall Wilton, MD, Ann Arbor
10 .... Max Wisgerhof, MD, Detroit
16 .... David J. Young, MD, Holland
10 .... Marcus Zervos, MD, Royal Oak
22 .... Paul Ziedel, MD, Detroit
10 .... A.P. Zingas, MD, Detroit

Cooperating Specialty Societies, Sections, Medical School Departments and Hospitals

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Michigan Academy of Family Physicians
Michigan Academy of Physicial Medicine and Rehabilitation
Michigan Academy of Plastic Surgeons
Michigan Allergy Society
Michigan Chapter, American Cancer Society
Michigan Chapter, American College of Surgeons
Michigan College of Emergency Physicians
Michigan College of Nuclear Medicine Physicians
Michigan Dermatological Society
Michigan Section, American College of Obstetricians and Gynecologists
Michigan Occupational Medical Association
Michigan Ophthalmological Society
Michigan Orthopaedic Society
Michigan Psychiatric Society
Michigan Radiological Society
Michigan Society of Anesthesiologists
Michigan Society of Colon and Rectal Surgeons
Michigan Society of Thoracic and Cardiovascular Surgeons
Michigan Thyroid Association
Michigan Urological Society
MSMS AIDS Provider Education Project
MSMS Committee on Aging
MSMS Committee on Bioethics
MSMS Committee on Concerns of Women Physicians
MSMS Task Force on Environmental Health
Orthopaedic Surgery Associates, P.C.

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University of Michigan Medical School

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Department of Family Medicine
Department of Neurological Surgery
Department of Pediatrics
Department of Radiology
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Hospitals

- Blodgett Regional Poison Center
- Children's Hospital of Michigan
    - Department of Pediatrics
    - Division of Infectious Diseases
- Harper Hospital
- Henry Ford Health System
- Henry Ford Hospital
    - Cardiac Intensive Care Unit
    - Division of Endocrinology and Metabolism
    - Department of Internal Medicine
    - Division of Plastic Surgery
- Hutzel Hospital
    - Department of Gynecology
    - Division of Reproductive Genetics
- Oakwood Hospital
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- St. Mary Hospital
    - Department of Critical Care Medicine and Pulmonary Medicine
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91 MSMS Annual Scientific Meeting, November 12, 13 & 14, Hyatt Regency Dearborn

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Take one-third off your registration fee if yo
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osing your courses: Please check the courses you wish to attend. For each, **please indicate a second choice** in case the first is already filled.
mum attendance figures have been set for each course, depending on room size.

sday Morning, November 12

a.m. to 12 Noon, Non CME Course)
_ Office Financial Management Seminar

to Noon, including break)
1 in blank for first choice and 2 for second choice)
_ Basic Cardiac Life Support
_ The Breast Lump: Workup and Treatment
_ Current Psychiatric Concepts: An Update
_ The Medical and Surgical Management of Coronary Occlusive Disease
_ Pulmonary Embolism: Etiology, Diagnosis and Treatment
_ Reproductive Endocrinology for the Primary Care Physician
_ Rheumatology Update Module
_ Traumatic Brain Injury and Spinal Cord Injury
_ Treatment of Hyperlipidemia
_ Update in Clinical Toxicology

Wednesday Morning, November 13

(7:15 - 8:15 a.m., No Fee)
____ "Early Bird" Plenary Session on "Substance Abuse: The Physician's Role" (Continental Breakfast Included)

(8:30 to Noon, including break)
(Write **1** in blank for first choice and **2** for second choice)
____ A Closer Look at Substance Abuse, Pregnancy, and Its Impact
____ Basic Cardiac Life Support
____ Common Ophthalmic Problems Faced by the Practicing Physician
____ Common Surgical Problems in Infants and Children
____ Communicating with the Female Patient Regarding Acute Health Issues
____ Concepts & Controversies in Laparoscopic Surgery
____ Environmental Issues in Primary Care
____ Mastering Common Thyroid Problems: A Case Study Approach
____ The Role of DNA Diagnosis in Clinical Practice

Thursday Morning, November 14

(7:15 - 8:15 a.m., No Fee)
____ "Early Bird" Plenary Session on "Genetics as Basis for Medicine in the 21st Century" (Continental Breakfast Included)

(8:30 to Noon, including break)
(Write **1** in blank for first choice and **2** for second choice
____ Attention Deficit Hyperactivity Disorder
____ Basic Cardiac Life Support
____ Current Approaches to the Management of the Obese Patient
____ Current Concepts in Blepharoplasty
____ Diagnostic Testing in Back Pain
____ Health Risks to Physicians
____ Interpretation of Arterial Blood Gases
____ Response to Medication in the Elderly
____ The Team Physician

ch: *A deli lunch is included in the course fee. Students and guests may purchase additional lunch tickets. Advance notice is requested so MSMS can give an accurate guarantee.*
se indicate which days you want a lunch ticket.

sday Deli Lunch ☐ **Wednesday Deli Lunch** ☐ **Thursday Lunch** ☐

esday Afternoon, November 12

0 to 5:00, including break)
te **1** in blank for first choice and **2** for second choice)
_ Bleeding, Clotting and Transfusion
_ Clinical Approaches to HIV
_ Fetal Medicine and Surgery in the 90's
_ Medical Management of BPH/Female Urology
_ Osteoporosis
_ Present & Future Issues in Clinical Hypertension
_ Radiology for Clinicians
_ Resurgence of Tuberculosis
_ Sedation and Analgesia for Outpatient and Office Procedures

Wednesday Afternoon, November 13

(1:30 to 5:00, including break)
(Write **1** in blank for first choice and **2** for second choice)
____ Allergy and Asthma - 1991
____ Breast and Prostate Cancer
____ Child Abuse Prevention: What Can We Learn From Non Human Primates
____ Dermatological Therapeutics
____ How to Choose From Alternative Imaging Techniques
____ Physician Services to Nursing Home Residents
____ Psychiatric Issues in the Work Place
____ Update on Inflammatory Bowel Disease

Thursday Afternoon, November 14

(1:30 to 5:00, including break)
(Write **1** in blank for first choice and **2** for second choice
____ Addiction or Affliction: The Relationship of Eating Disorders and Chemical Dependen
____ Adolescent Sexuality Education
____ Biomedical Ethics: Urban Health System Perspectives
____ The Clinical Evaluation and Differentiation of the Dementias
____ Management of Lower Extremity Injuries in
____ Management of The Post MI Patient
____ The Resurgence of Childhood Diseases, and New Trends in Immunizations
____ Selected Topics in Plastic Surgery
____ Update on Gestational Diabetes Mellitus

our payment

ISMS Members: $50 per course
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esidents: $25 per course
on-Members: $75 per course
tudents: No course fee

NOTE: *Each person attending must pay a 15 one-time registration fee. Includes registration naterials, handouts, refreshments, etc.*

Multiply total number of half-day courses by appropriate fee:

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end this entire page with your check. *Confirmation of your reservation will be sent to you.*

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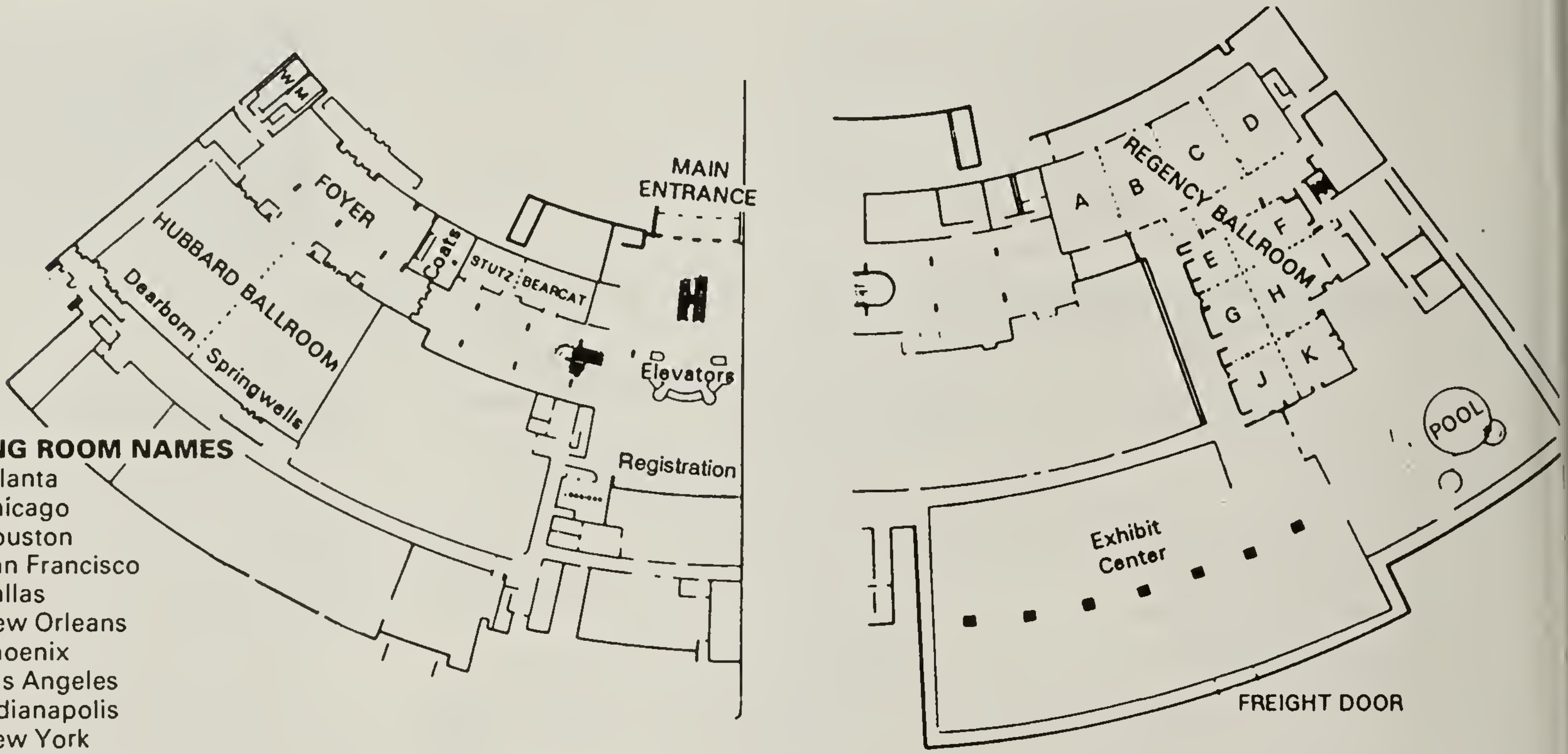
1991 MSMS Annual Scientific Meeting November 12, 13, & 14 Hyatt Regency Dearborn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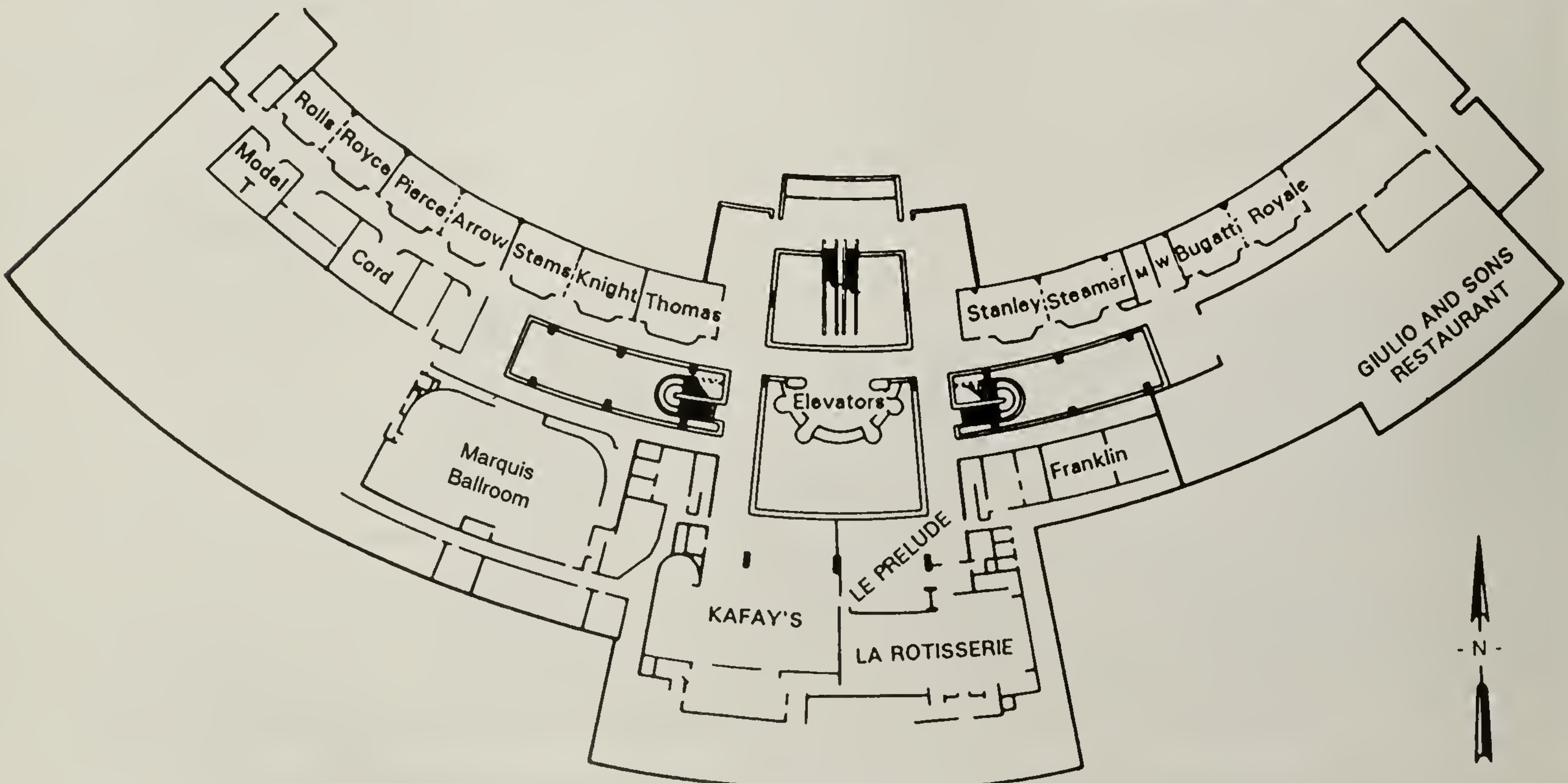
Conference Suite Level Second Floor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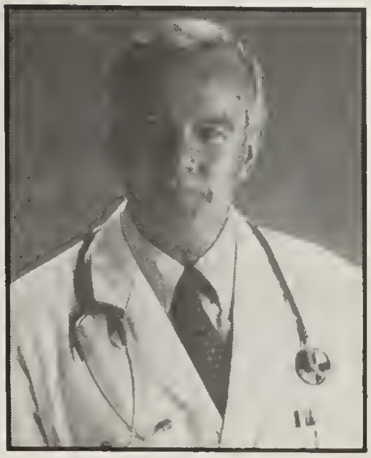

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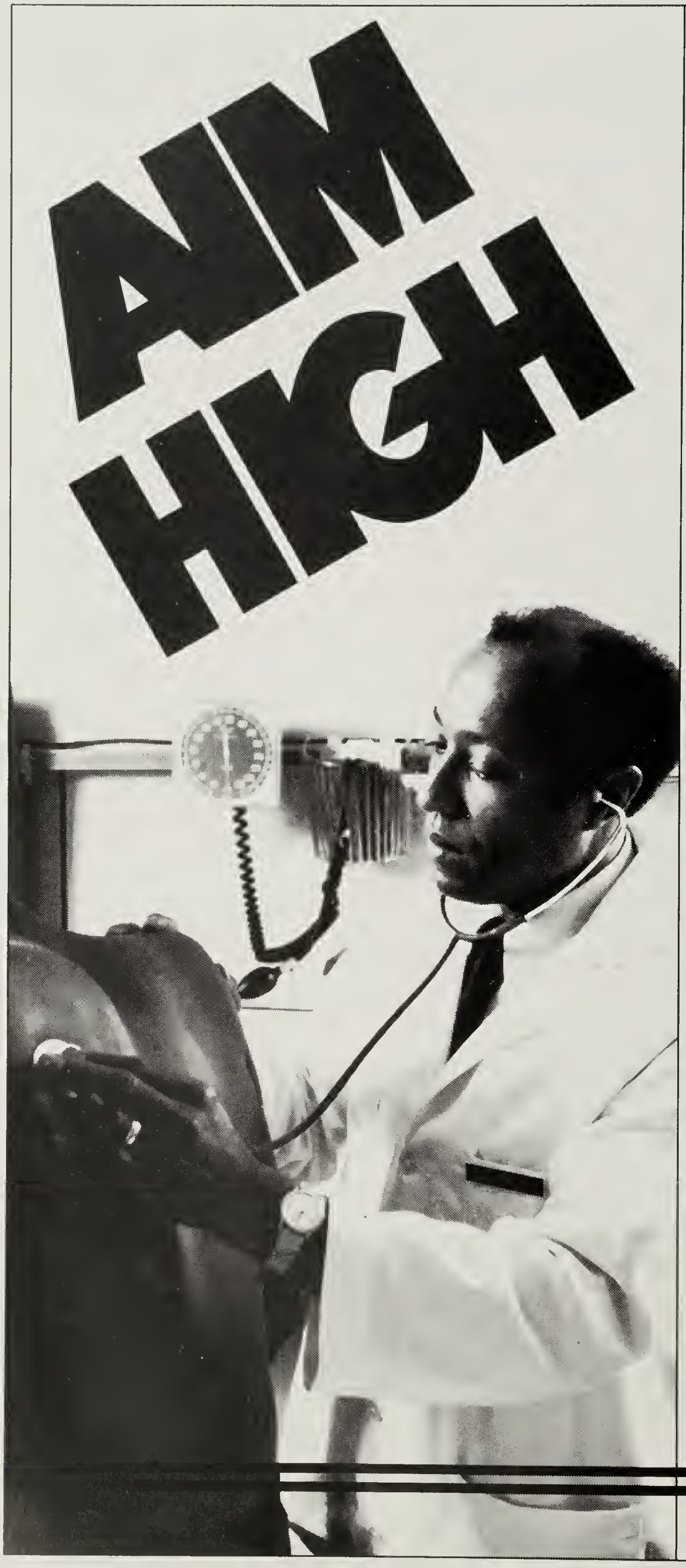

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See you at ASM booth 504.

OBITUARIES

Paul M. Becker, MD

Franklin

Paul M. Becker, MD, an internist, died December 6, 1990. He was 61. Doctor Becker graduated from Rheinische Friedrich Wilhelm University, Bonn, Germany, in 1956. He served his internship at Harper Hospital, Detroit, and his residency at William Beaumont Hospital, Royal Oak. He established a private practice in Birmingham in 1962. Doctor Becker had retired from practice a few months prior to his death. He was a member of the Oakland County Medical Society and MSMS.

Roland R. Benson, MD

Grand Rapids

Roland R. Benson, MD, a radiologist, died April 26. He was 83. Doctor Benson was director of St. Mary's Hospital Department of Radiology from 1946 until his retirement in 1967. He received his medical degree from Wayne State University in 1935. He was a life member of the Kent County Medical Society and MSMS.

Gerald S. Buchanan, MD

Asheville, North Carolina

Gerald S. Buchanan, MD, a family physician, died April 20. He was 71. Doctor Buchanan attended Union College, Lincoln, Nebraska. He received his medical degree from Loma Linda University in 1950. Doctor Buchanan practiced medicine in Holly for more than 30 years. He retired in 1985 and moved to North Carolina. He was a member of MSMS.

Robin C. Buerki, MD

Grosse Pointe Farms

Robin C. Buerki, MD, a neurosurgeon, died June 2. He was 98. Doctor Buerki graduated from the University of Wisconsin and received his medical degree from the University of Pennsylvania in 1917. He started a private practice in Idaho and later in Oregon. In the 1920s he served as vice president of medical affairs at the University of Pennsylvania and then joined Henry Ford Hospital. Doctor Buerki is the former executive director of Henry Ford Hospital, Detroit, a position he held for 13 years. An auditorium on the Henry Ford Hospital campus was named after Doctor Buerki. He was a founding fellow of

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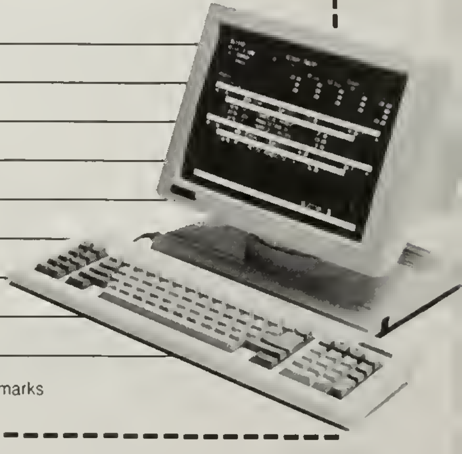

See you at ASM booth 409.

OBITUARIES

the American College of Hospital Administrators; former president of the American Hospital Association and former vice president of the National Health Council. Doctor Buerki remained active in medical organizations until age 95. Last year, he was inducted into Modern Healthcare Hall of Fame in Philadelphia. He was a member of the AMA and MSMS.

Charles G. Child, III, MD

Atlanta, Georgia

Charles G. Child, MD, a general surgeon, died June 23. He was 83. Doctor Child graduated from Yale University and Cornell University Medical College. He was professor and chairman of the Department of Surgery at Tufts University School of Medicine, Boston from 1953-58. He came to the University of Michigan as head of surgery in 1958, and held that post until 1974. In 1972 he was given the U-M's distinguished faculty achievement award. In 1977, he accepted a professorship in surgery at Emory University, Atlanta and served on staff of the Veterans Administration Hospital. Doctor Child was a member of MSMS.

Morris I. Goldin, MD

West Bloomfield

Morris I. Goldin, MD, a psychiatrist, died May 8. He was 83. Doctor Goldin received a bachelors degree from Detroit College of Medicine and earned his medical degree from Wayne State University School of Medicine. He served as medical director for 35 years at Carlyle Center. Doctor Goldin served on staff of Harper Grace Hospital, Detroit; South Macomb Hospital, Detroit; and Glen Eden, Warren. He was a member of the American Medical Association and MSMS.

John W. Hauser, MD

Petoskey

John W. Hauser, MD, a urologist, died June 25. He was 78. Doctor Hauser attended the University of Cincinnati where he received his bachelor's degree and his medical degree in 1937. He completed five years of surgical training in Cincinnati, Philadelphia and New York. Doctor Hauser practiced in Cincinnati and in 1973 moved to establish a practice in Petoskey. He was a member of MSMS.

James A. Millard, MD

Ada

James A. Millard, MD, a general practitioner, died August 9. He was 68. Doctor Millard was the former chief of family practice at Blodgett Memorial Hospital, Grand Rapids.

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OBITUARIES

He was a member of the Kent County Medical Society and MSMS.

Irving E. Silverman, MD

Okemos

Irving E. Silverman, MD, a family physician and anesthesiologist, died June 7. He was 78. Doctor Silverman graduated from Michigan State University and received his medical degree from the University of Michigan College of Medicine in 1938. He was honored by the Michigan State Medical Society for 50 years of service. Doctor Silverman served as president of the Ingham County Medical Society; chief of staff of Ingham Medical Center; vice-chief of staff of E. W. Sparrow Hospital, where he served six years as a member of the Medical Executive Committee and Chief of Family Practice; chief of anesthesia and member of the Executive Committee of St. Lawrence Hospital. He was a member of MSMS.

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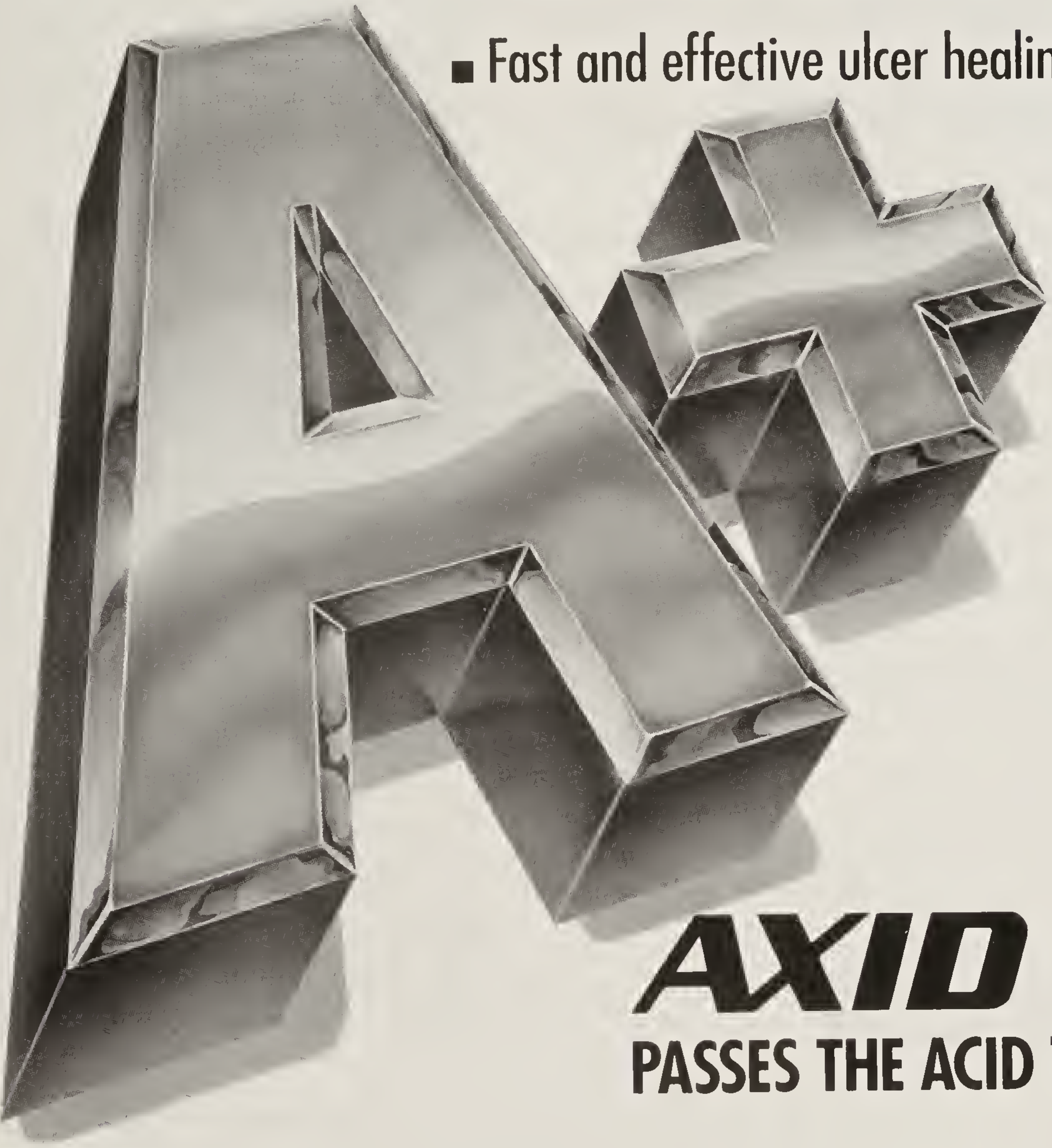

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3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests–False-positive tests for urobilinogen with Multistix® may occur during therapy

Drug Interactions–No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility–A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy–Teratogenic Effects–Pregnancy Category C–Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers–Studies in lactating women have shown that 0 1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother

Pediatric Use–Safety and effectiveness in children have not been established

Use in Elderly Patients–Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities Age alone may not be an important factor in the disposition of nizatidine Elderly patients may have reduced renal function

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0 2%), urticaria (0 5% vs <0.01%), and somnolence (2 4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug

Hepatic–Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular–In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS–Rare cases of reversible mental confusion have been reported

Endocrine–Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo Gynecomastia has been reported rarely

Hematologic–Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist This patient had previously experienced thrombocytopenia while taking other drugs Rare cases of thrombocytopenic purpura have been reported

Integumental–Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported

Hypersensitivity–As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported Rare episodes of hypersensitivity reactions (eg. bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other–Hyperuricemia unassociated with gout or nephrolithiasis was reported Eosinophilia, fever, and nausea related to nizatidine have been reported

Overdosage: Overdoses of Axid have been reported rarely If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References

1 Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987,22(suppl 136).61-70
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55
4 *Am J Gastroenterol* 1989,84.769-774

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Additional information available to the profession on request

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

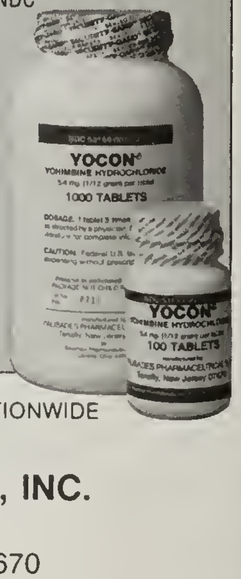
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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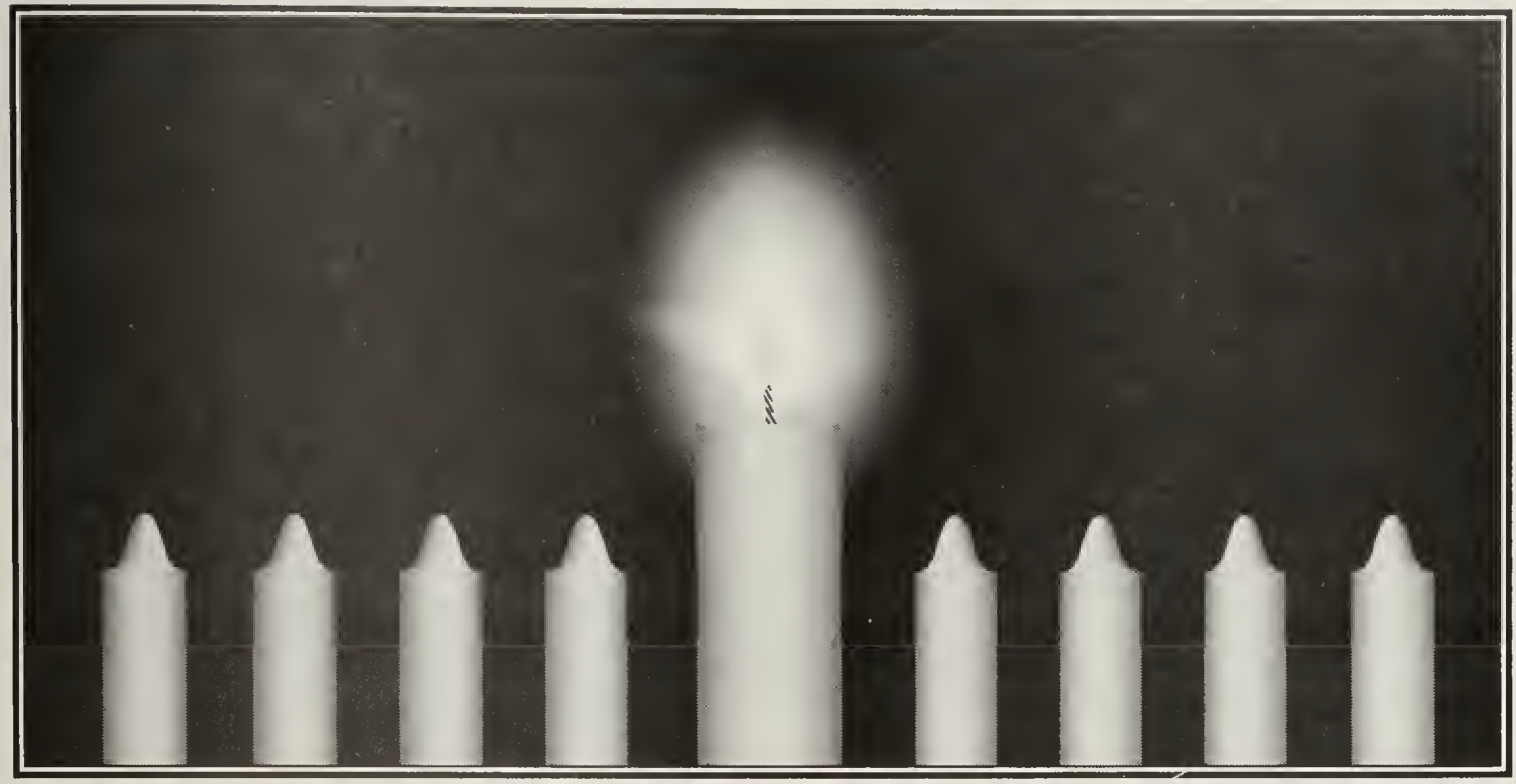

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MEETINGS

MSMS Meetings

October

16, MSMS Practice Management Seminar "Retirement Planning." University Club, East Lansing, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

22, 23, 24, MSMS Practice Management Seminar "1991 BCBS Medicare Update Series." October 22 - University Club, East Lansing, MI; October 23 - Dearborn Inn, Dearborn, MI; October 24 - Bay Valley Inn, Bay City, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

24, MSMS Practice Management Seminar "Kerr, Russell, and Weber - Health Law Update (1/2 day)." Ann Arbor Regent, Ann Arbor, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

29, 30, 31, Nov 1, AMA-MSMS Medical Office Staff Training Series. Dearborn Inn, Dearborn, MI. Contact: MSMS Office of Physician Education, (517) 337-1351.

November

12-14, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, MI. Over 50 courses offered. Contact: MSMS Office of Physician Education, (517) 337-1351 for a complete meeting program.

AMA Meetings

September

13-15, Rural Health Care, "Strategies to Increase Access." Hyatt Regency, Dearborn, MI. Contact: Department of Registration Services, American Medical Association, 515 N. State St., Chicago, IL 60610, (800) 621-8335.

Michigan Specialty Society Meetings

October

17, Family Trauma and Therapeutic Interaction: A Humanizing Approach, Southfield, MI. Contact: (313) 557-8633.

24-27, 16th Annual Membership and CME Conference-Diagnostic and Therapeutic Office Procedures, Holiday Inn, Traverse City, MI. Contact: Jim Nelson, (517) 371-3850.

26, The Universal Resistance to Child Analysis, Chicago, IL. Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

November

7, On Freud's Adolescence: Freud, Gisela, Silberstein and the Repudiation of Femininity, Ann Arbor, MI. Contact: (313) 557-8633

16, Seventeenth Annual Symposium, "Improving Clinical Skills: Lessons from Longer Psychoanalytic Treatments." Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

December

7, Cries and Whispers, Royal Oak, MI. Contact: (313) 557-8633.

National Specialty Society Meetings

October

10-13, American Society of Internal Medicine, 35th Annual Meeting. Contact: Lisa Derby, (202) 289-1700 ext. 615.

Other Meetings

October

10, Clinical Care and Management of the HIV-Infected Patient, Toledo, OH. Contact: Susan Hahn, (419) 381-4237.

Continued on page 43

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MEETINGS

23, Dating Violence, Toledo, OH. Contact: Susan Hahn, (419) 381-4237.

31, Nov. 1, 2, Second Annual Family Practice Update, Toledo, OH. Contact: Susan Hahn, (419) 381-4237.

November

6, Crohn's & Colitis Foundation of America, Ingham Medical Center, Lansing, MI. Contact: Linda Rockey, (517) 676-4870 or Floyd Barrows, (517) 669-5314.

December

4, Crohn's & Colitis Foundation of America, Ingham Medical Center, Lansing, MI. Contact: Linda Rockey, (517) 676-4870 or Floyd Barrows, (517) 669-5314.

12, Update in Cardiovascular Disease 1991, Toledo, OH. Contact: Susan Hahn, (419) 381-4237.

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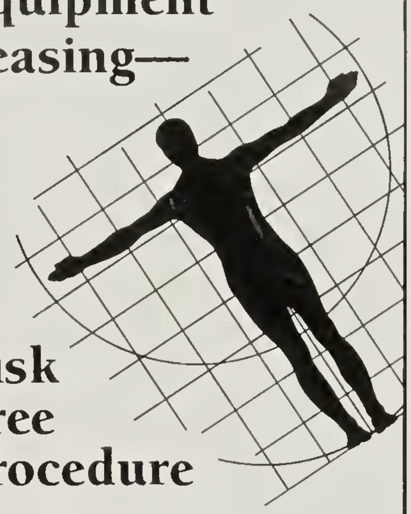

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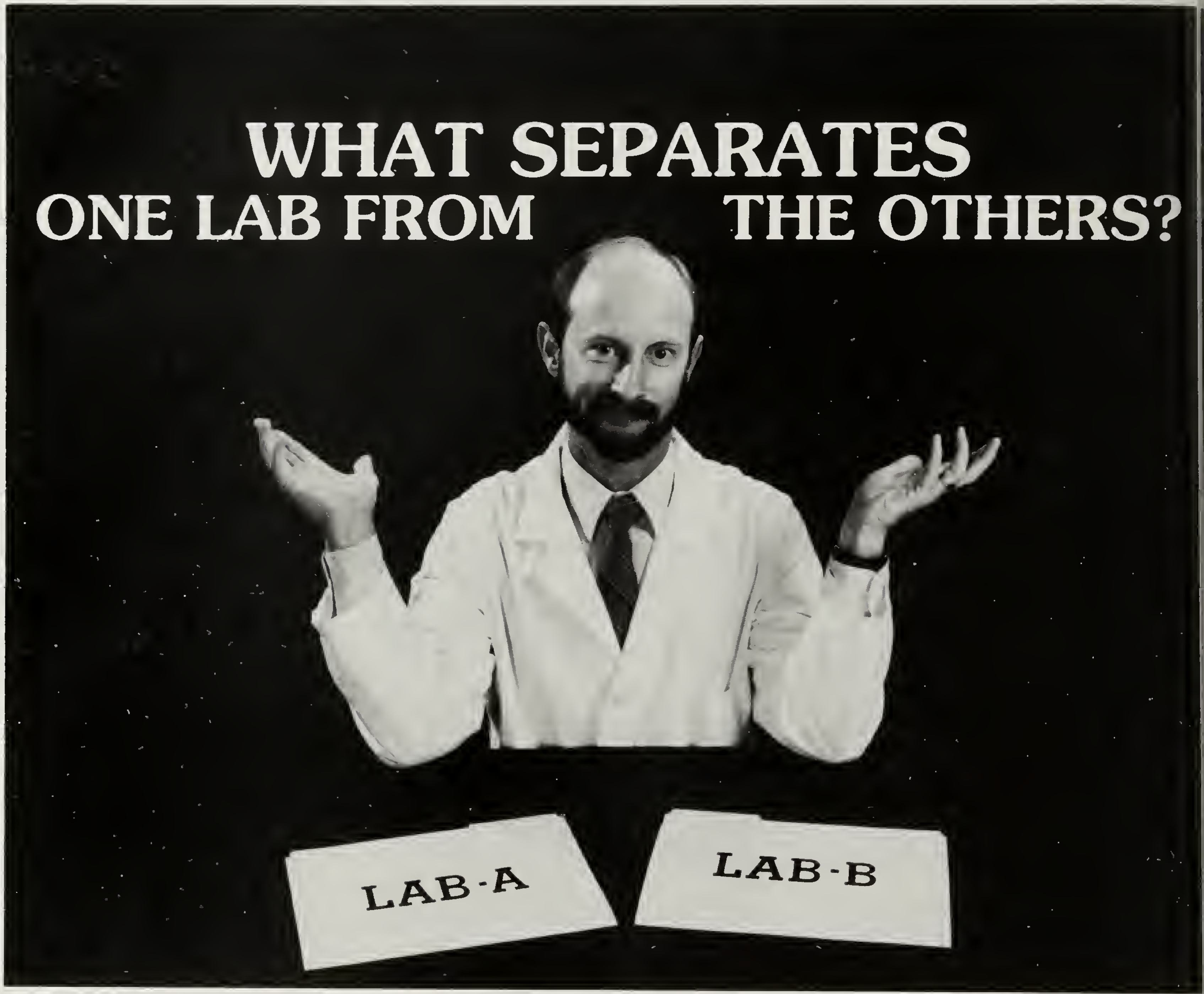

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

October

19, Advanced Cardiac Life Support Recertification. Location: Lansing Community College, Lansing, Michigan. **Sponsor:** Lansing Community College. **Contact:** Kathy Hovey, RN, Lansing Community College, 34-Continuing Health Careers, Health Careers Technology, P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-1414. **Approved for:** 6 hours Category I Credit.

17-19, Modern Perinatal Problems. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jones, Registrar, Office of Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 16 hours Category I Credit.

20-21, Fiberoptics Workshops for the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jones, Registrar, Office of Continuing Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 15 hours Category I Credit.

25-26, Advanced Cardiac Life Support Instructors Course. Location: Bay Valley Hotel & Resort, Bay City, Michigan. **Sponsors:** Michigan Chapter of the American College of Emergency Physicians and American Heart Association of Michigan. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 16 hours Category I Credit.

31-Nov. 2, 21st Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center, Grand Rapids, Michigan. **Sponsors:** International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Genevieve de Groot Swanson, MD, Blodgett Professional Bldg, 1900 Wealthy, SE, Suite #290, Grand Rapids, MI 49506, (616) 774-0440. **Approved for:** 18 hours Category I Credit.

Continued on page 47

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CATEGORY I COURSES

November

7-8, Selected Topics Clinical Nutrition. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, College of Pharmacy. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

14-15, Advanced Pediatric Life Support Course. Location: Children's Hospital, Detroit, Michigan. **Sponsors:** American Academy of Pediatrics and Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

16-17, Pediatric Advanced Life Support Certification. Location: Lansing Community College, Lansing, Michigan. **Sponsor:** Lansing Community College. **Contact:** Kathy Hovey, RN, Lansing Community College, 34-Continuing Health Careers, Health Careers technology, P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-9619. **Approved for:** 16 hours Category I Credit.

18-19, 15th Annual Michigan Fall Radiology Conference. Location: Townsend Hotel, Birmingham, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 14 hours Category I Credit.

23-24, Second International Guillain-Barre Syndrome Symposium. Location: Radisson Hotel, Manhattan Beach, California. **Sponsors:** Wayne State University School of Medicine, Department of Neurology and the Guillain-Barre Syndrome Foundation International. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 13 hours Category I Credit.

December

6-7, Advances in Psychiatry. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869. **Approved for:** 12 hours Category I Credit.

January

27-29, Fiberoptics Workshops for the Difficult Airway. Location: Disney's Yacht and Beach Club Resort, Lake Buena Vista, Florida. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869. **Approved for:** 15 hours Category I Credit.

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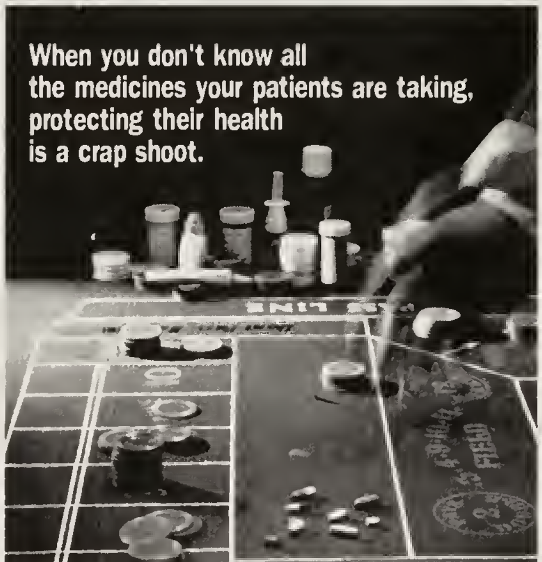

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lievably, this summer it has had a higher ozone rating than Detroit. Air pollution has drifted up Lake Michigan from the traffic, factories and other industry of the southern lakeshore; Chicago and Gary, Indiana.

Even though enforcement and awareness has improved Michigan's water over the past 20 years, 80 percent of our largest inland lakes are still threatened by pollution, according to the Department of Natural Resources. A recent DNR study indicated 390,000 of 490,000 acres contained in 684 inland lakes are threatened by pollution, erosion from shoreline development, uncontrolled storm water runoff or chemical runoff from cities and farms.

Enforcement of environmental laws concerning contaminated land also appears to be lax, if not impossible. A recent series of stories by *The Detroit News* said "DNR experts now say the entire Detroit riverfront is contaminated to some degree by hazardous waste deposited to fill swampy areas and wetlands, or by the debris of industries that formerly occupied the land." The story quoted a DNR official as saying the state has been enforcing cleanup rules with great flexibility to accommodate Detroit's redevelopment efforts.

Building condominiums and marinas on toxic waste sites is one thing, schools is another. In August, angry parents of school children at Cooper Elementary School in Livonia were livid about the toxic chemicals found around the school built on a previous landfill site in 1962. They want the school closed permanently. According to a news report, "the state ordered a portion of the playground closed in May when dangerous contaminants, including DDT, mercury, arsenic and, later, lead and cadmium, were found in soil and school carpet samples." The school grounds have been listed on the state's priority list of contaminated sites since 1984.

The state has identified about 2,800 toxic sites in Michigan that need to be cleaned up. The Environmental Protection Agency has identified 77 Superfund contamination sites in Michigan, fifth highest in the nation. Cleanup is costly and slow, if existent at all.

As protectors of the public health, it is imperative that Michigan's medical doctors take a serious lead in the effort to clean up our environment. We must become aware of environmentally rooted illnesses, keep an eye out for morbidity and mortality trends related to environmental factors, and most of all we must become leaders within our own communities in the cause for a cleaner, safer, healthier environment.

The trouble with fouling one's own nest is that you have nowhere to turn and no one to blame. In part, we're all responsible. Now we all must work to clean house, or continue to look at a blueprint for disaster. ■

Doctor Burton is MSMS president.

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U.S. Army Recruiting	20
University of Michigan	48
VERSYSS, Inc.	34

Fouling one's own nest: Blueprint for disaster

By Robert D. Burton, MD

Each year after exams, a small knot of us book-weary medical students exchanged our textbooks for fishing rods and tackle boxes, piled our duffle into a trusty V-8 and headed for a pristine trout-laden lake in Canada just north of Sault Ste. Marie.

We continued this joyous outdoor tradition throughout medical school and beyond. The camaraderie and the fresh air, fresh water and fresh fish frying over an open fire seemed an addiction.

Each year, however, we noticed a small change in our annual foray.

For some reason, we had to go farther north into Canada to find the same clear waters—which the lake trout demand—that we had found closer to the Soo in the previous year.

We didn't think much of it then, but it was a harbinger of things to come. The lake trout, like the canary in the mine shaft, were telling us something. Silently, the side effects of our increasingly industrialized society were sneaking up on us.

Pollution of the water, air and land is such a known quantity—such a fact of life—these days that it seems no longer shocking when we hear of a newly discovered toxic waste dump, or a contaminant discharged into our waterways or an ozone warning.

But in just the last few weeks the news of pollution in Michigan and around the world would provide enough material for a sequel to Rachel Carson's "Silent Spring."

It's not shocking when Michigan, keeper of the world's greatest reserve of fresh water, is ranked 17th on the "Green Index," a compilation of 256 indicators to measure and rank each state's environmental health. But is it more shocking when the same index shows Michigan as the next to worst state in toxic chemicals sent from factories to disposal or treatment sites? According to a New York-based think tank, toxic chemicals are released into the Michigan environment or sent to disposal sites at twice the national average. In Michigan, the rate from the 1988 data was 3,959 pounds—nearly two tons — of toxic waste per square mile released or treated. The national average was 1,745 pounds per square mile. This data, of course, says nothing about the public exposure, but it seems where there is smoke, there is cause for concern.

The Green Index also shows Michigan is next to worst in the percent of public sewers in noncompliance with federal regulations. One of those public sewers is owned by the otherwise neat and tidy Dutch community of Grand Rapids, my home. It is ironic—actually, painfully embarrassing—that with every moderate rain shower, the city's inadequate sewerage system spews millions of gallons of raw sewage into the Grand River. Our raw sewage then flows downstream to the beautiful Lake Michigan shoreline tourist community of Grand Haven. If a city such as Grand Rapids, with its strong Dutch tradition of "cleanliness is next to Godliness," will allow such a problem to continue, can pollution anywhere else seem shocking?

How about in the Upper Peninsula's pretty Garden Peninsula that juts down into Lake Michigan between Manistique and Escanaba? Unbe-

Continued on page 55

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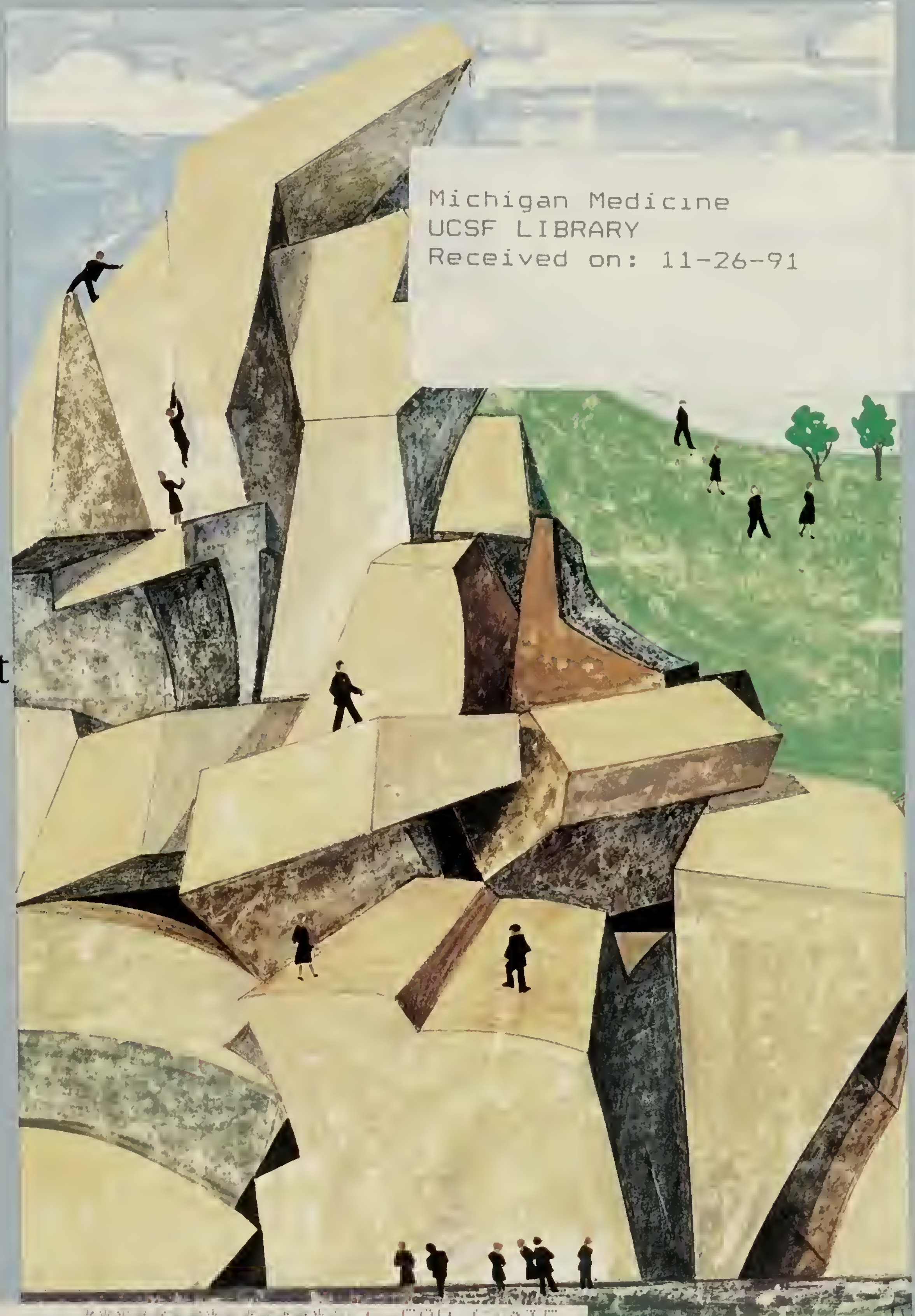

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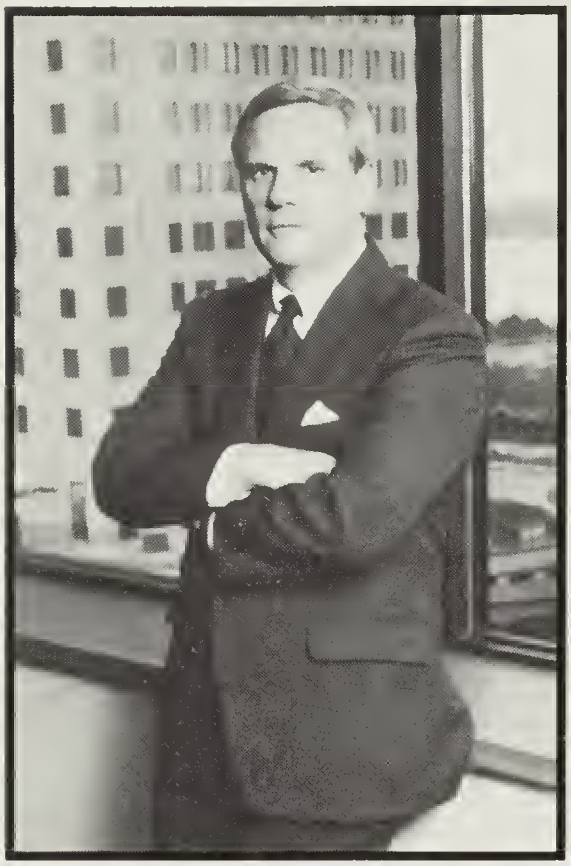

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Michigan State Medical Society (MSMS) leaders discuss the many services which Physicians Service Group (PSG) offers to physicians. Seated are (from left to right) PSG President and MSMS Treasurer Billy Ben Baumann, MD; MSMS Finance Committee Chairman B. David Wilson, MD; MSMS President Robert D. Burton, MD; MSMS Board Chairman Jack L. Barry, MD; and MSMS Executive Director William E. Madigan.

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MICHIGAN MEDICINE

NOVEMBER 1991 VOLUME 90, NO 11
Award-Winning Journal of the Michigan State Medical Society

COVER STORY

MSMS is committed to satisfying member needs. That is the message of Dorothy Kahkonen, MD, chairman of the MSMS Committee on Membership Recruitment and Retention. That is also the message of this month's cover story, which begins with a letter from Doctor Kahkonen. Following her letter, this month's cover story includes a roundup of current MSMS section activities; a message from the chairman of the Michigan Doctors Political Action Committee; a discussion of the importance of joining organized medicine; an explanation of the American Medical Association's MD-2000 campaign; a letter to physicians' spouses; demographic information; and a list of whom to call at MSMS.

35

Medicare Fraud & Abuse Safe Harbor Regulations

MSMS legal counsel explain safe harbor regulations issued recently by the Department of Health and Human Services which exempt 11 health care business practices from prosecution under the Medicare anti-kickback statute.

By Paul M. Shirilla and Patrick J. Haddad

38

Board of Medicine Actions

DEPARTMENTS

5 REIMBURSEMENT ROUNDUP
7 MSMS ON THE MOVE
9 MEDICAL NEWSFRONTS
11 PHYSICIANS IN THE NEWS
41 NEW MEMBERS
47 MEETINGS
48 CATEGORY I COURSES
53 CLASSIFIEDS
55 ADVERTISING INDEX
56 PRESIDENT'S PAGE

In next month's issue:
Medical liability update

Cover illustration: *By Robert L. Brent*

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Reimbursement Roundup

By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

Reimbursement Roundup addresses third party payer reimbursement issues affecting physician practices. The column appears every other month in *Michigan Medicine*. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with BCBSM and its Subcommittee on Medicare Carrier Problems.

Non-covered Benefit – Number One Rejection

BCBSM reported the most common rejection in August was 033. It read: "The subscriber's contract does not cover this service." The bad news is that BCBSM issued 281,138 of these rejections — and your cost to collect the money has risen. Your staff will handle each account at least three times as much, you may incur phone/mailing charges and you risk the loss of opportunities had you collected the money at the time of service. The good news is that your office can have control of this situation with some effort and organization. Here's how.

■ *Knowledge and use of the* MUPC *manual and the* MATRIX *manual* — Your MUPC manual provides valuable information on the right side of the procedure. It tells you which insurances do not cover the procedure as well as which contracts do cover it. It will let you know whether you need supplementary documentation, whether to specify a quantity, and it lists different codes for the same procedure for different carriers. The revision date of 3-1-91 should be listed at the bottom of each page.

The next update will be 3-1-92.

The MATRIX manual lists the benefits of each contract using the Blue Shield numbers on the insurance card (usually the middle four digits of the service code). For example:

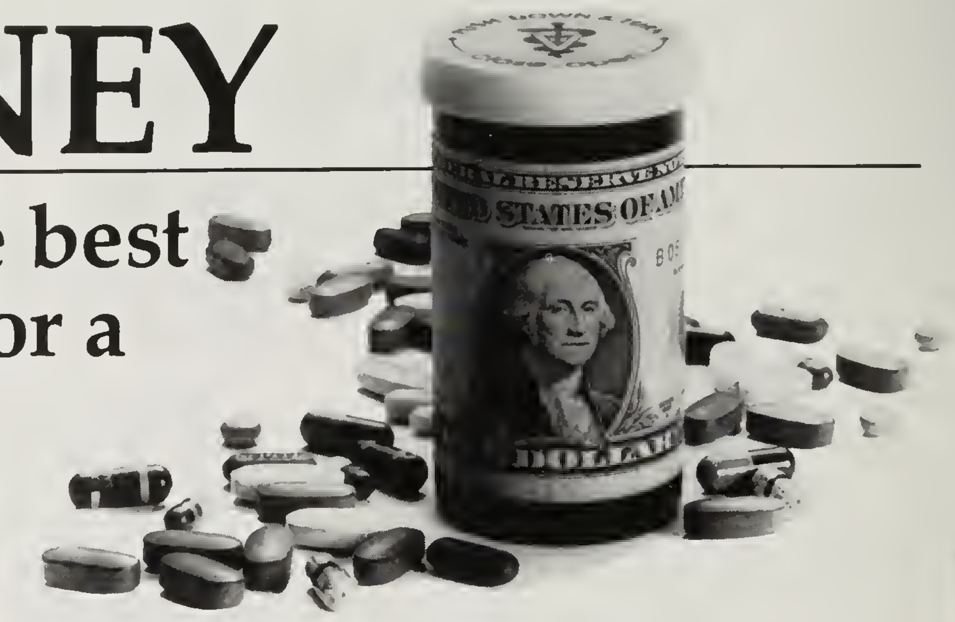
LF2D MVF 1 FAE-RC PD CLC
PPNVI VST MM

MVF 1 - in bs manual(section 2-2) lists basic benefits (lab, xray, ekg, anes, inpt care, etc.)
FAE-RC - emergency first aid reasonable charge
PD - prescription drugs
CLC - extended care facility benefits
PPNVI - pre and postnatal visits
VST - voluntary sterilization
MM - master medical NO office visit and injection coverage

If you look in the MUPC for office call coverage, for instance, 90060, it states non-covered by MVF contracts.

The updates to the service code manuals are published in *The Record*. You can write for the service code manuals at this address: Manual Processor, Material Management L-800 53200 Grand River, New Hudson MI 48165. The cost is $80.

Some 200 physicians are involved in a BCBS pilot program called DENIS. This would allow providers computer access to patient benefits. It is unknown as to when it will be available. ■



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MSMS *ON THE MOVE*

A monthly update of key MSMS activities

State high court sides with physicians on liability defense

A unanimous Michigan Supreme Court decision last month scored a significant medical liability victory for Michigan physicians. The ruling will aid defendants in medical liability disputes to obtain information for their defense from a plaintiff's other treating physicians. The decision was consistent with an MSMS legal brief filed with the Court on behalf of Michigan physicians.

The Court ruled that a defense attorney can conduct an ex parte interview (one-on-one informal interview as opposed to a costly formal deposition with attorneys for both sides present) to obtain information from a plaintiff's other physicians.

The decision overturned previous lower court decisions that held a defense attorney cannot discuss a case with a treating physician outside of formal information-gathering procedures.

Medical students benefit from risk management program

A unique risk management program targeting medical students is underway at Michigan State University. MSMS and the Michigan Physicians Mutual Liability Company (MPMLC) developed the lunchtime program to help physicians-in-the-making increase their awareness of risk management. The three-part series, which continues through November, is being offered to students in the MSU Colleges of Human Medicine, Osteopathic Medicine, and Nursing.

MSMS leaders talk about BCBSM provider class plan development

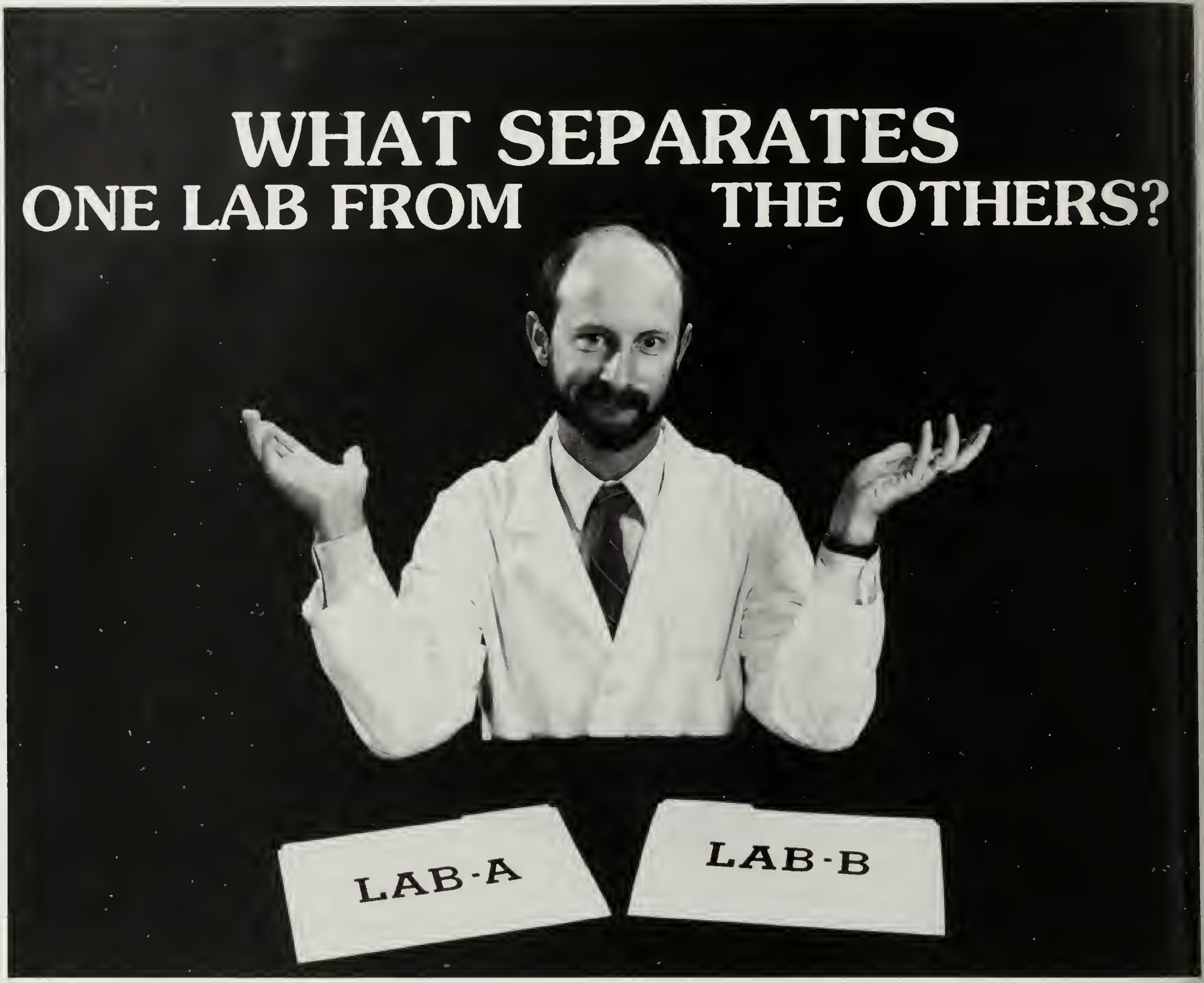
MSMS began discussions last month on developing portions of a new Blue Cross Blue Shield of Michigan (BCBSM) provider class plan. MSMS leaders brainstormed on elements of the plan, which outlines how BCBSM for a two-year period will comply with legal requirements of Public Act 350.

The session was part of MSMS strategy to move forward on problem resolution with BCBSM despite the fact that a Michigan Insurance Bureau-appointed independent judge declared that the 1987-1988 BCBSM Provider Class Plan violated state law. In that ruling, BCBSM was given six months to develop a new provider class plan. Though BCBSM has filed an application for appeal and a motion to stay the order until the appeal is heard, MSMS, in an unprecedented move, is taking the initiative to begin work on parts of a new provider class plan.

MSMS lobbies Congress to enforce HCFA behavioral offset cut

MSMS is working to ensure fair physician payment reform through its support of two federal bills that would prevent the Health Care Financing Administration (HCFA) from including a 6.5 percent behavioral offset reduction in its rules to implement the resource-based relative value scale (RBRVS) payment system. MSMS urges members to contact their congressmen to lobby sponsorship of House Resolution 3070 and Senate Bill 1810. For further information, contact Kevin Kelly at MSMS.

For details call William E. Madigan, *Executive Director*, MSMS, 517/337-1351.



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MEDICAL NEWSFRONTS

Laser treatment shown to reduce severe vision loss from macular degeneration

Laser therapy successfully reduces severe vision loss among patients with age-related macular degeneration who have abnormal blood vessels under the center of the retina.

Researchers at William Beaumont Hospital's Eye Institute and 15 other clinical centers throughout the country recently announced this finding from the Macular Photocoagulation Study, funded by the National Institute and National Institutes of Health.

"The new results probably double the number of people with age-related macular degeneration who might benefit from laser treatment in the United States, to about 30,000 individuals each year," according to Raymond Margherio, MD, one of the study's principal investigators at the Beaumont Eye Institute.

"The study conclusively showed that laser treatment applied to abnormal blood vessels that occur under the very center of a patient's vision is better than no treatment at all in preserving long-term vision," Doctor Margherio said.

One third of hospitalizations for psychiatric care may not be necessary, study shows

Nearly four out of every 10 hospital stays for mental health and substance abuse treatment appear to be unnecessary, according to a recently-published joint study by the Michigan Health Care Education and Research Foundation (MHCERF) and Blue Cross and Blue Shield of Michigan (BCBSM).

The percentage of unnecessary hospital stays identified in the study varied according to the diagnoses. Substance abuse cases had the highest rate of unnecessary acute care inpatient admissions at approximately 75 percent. For mental diseases and disorders, unnecessary hospital stays ranged from 20 to 40 percent.

The study did not find that the care provided was unnecessary or of poor quality. It did conclude that patients did not need to be hospitalized in an acute care setting for the care and treatment they received.

Records of 539 patients selected randomly at 61 hospitals located in a 13-county area of southeast Michigan were used in the study. All of the patients had BCBSM coverage.

Researchers recommended that mental health and substance abuse cases be reviewed before inpatient hospital admission takes place, and that treatment be coordinated by a case manager. They also suggested that paying doctors and hospitals fixed fees based on diagnosis would encourage shorter and more cost-conscious institutional care.

Beaumont seeks volunteers for cholesterol study

William Beaumont Hospital's Clinics of Preventive and Nutritional Medicine are seeking volunteers for a 24-week research study of cholesterol.

Participants must be age 21 years of age or older, male or female, with slightly elevated cholesterol. Volunteers must be currently following an "American Heart Association" (i.e. low-fat, low cholesterol) diet. Female volunteers must be of non-childbearing potential. All participants must be in good general health.

For more information, or to volunteer, call the Beaumont Clinics at 313-645-8158.

U-M Cancer Center receives comprehensive designation from NCI

The University of Michigan Cancer Center has been designated a comprehensive center by the National Cancer Institute, ranking it among just 28 such facilities in the country.

The national ranking is significant because it means the center is a "major national source of the best new ideas in the laboratory, clinical and cancer prevention research," according to the NCI.

"We are thrilled that we have met the stringent requirements of the NCI and are now designated — along with only a select group of others in the United States — as a comprehensive cancer center," said Max S. Wicha, MD, U-M Cancer Center director. "We have worked very hard to achieve this."

MSMS Executive Director named to special AMA advisory committee

MSMS Executive Director William E. Madigan was recently named to a special advisory committee to AMA Executive Vice President James S. Todd, MD. Mr. Madigan is one of four state medical society executives appointed to serve on the committee, which will meet quarterly. The committee will advise Doctor Todd on all matters affecting the AMA. ■

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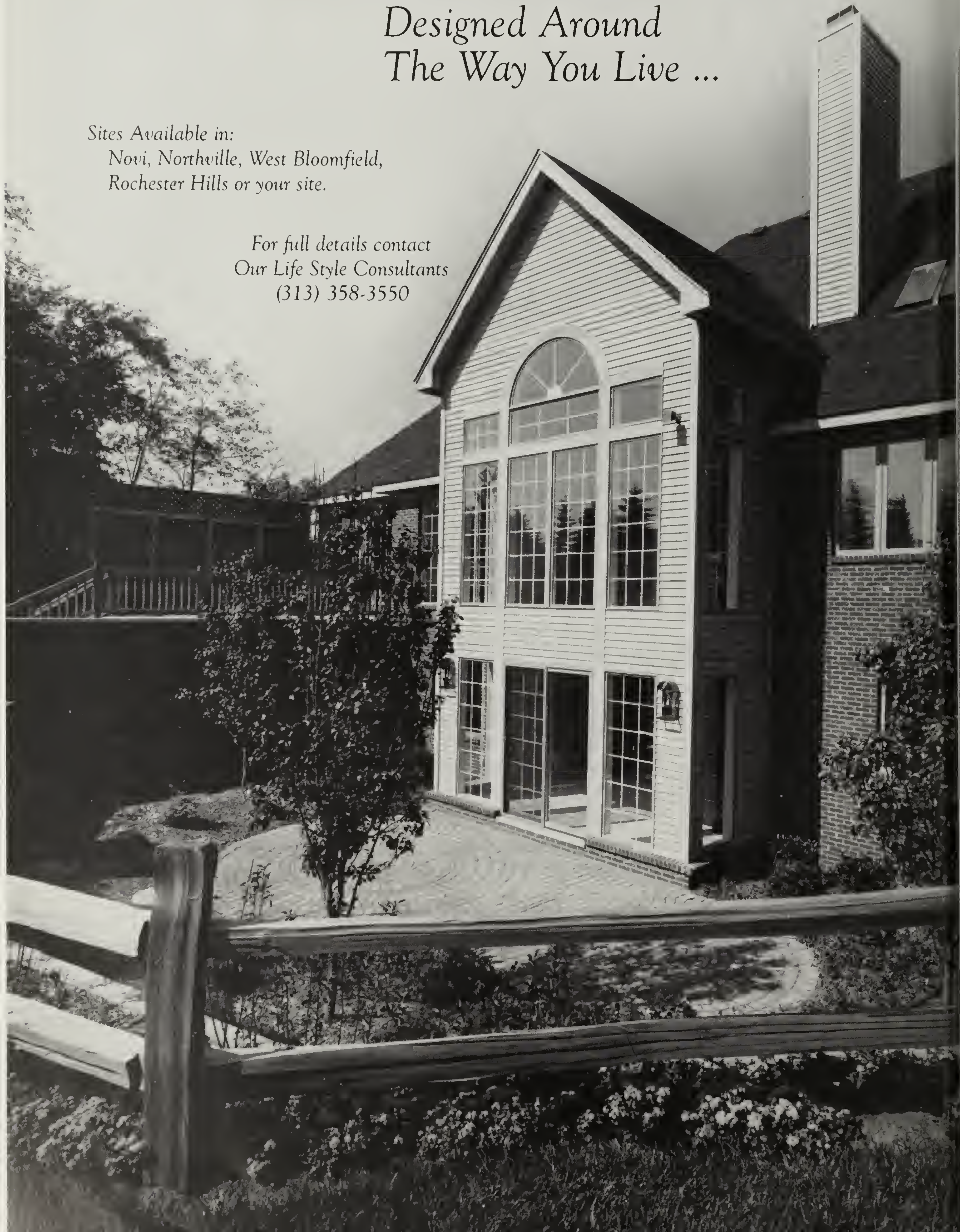

PHYSICIANS IN THE NEWS

Cathy O. Blight, MD, *is the 1991 recipient of the Herbert Lansky Memorial Award.* She was bestowed with this award for her many contributions to pathology and to the field of medicine in general. Currently senior associate pathologist at Hurley Medical Center, Flint, Doctor Blight is a member of the MSMS Board of Directors.

Steven E. Minnick, MD, *director of Medical Education, St. John Hospital and Medical Center, Detroit,* is a newly-elected member at large of the Board of Directors of the Association for Hospital Medical Education (AHME). In addition to his medical education responsibilities at St. John Hospital, he is also the Michigan State Medical Society's representative to the Michigan Council on Graduate Medical Education and is completing a two-year term as president of the Michigan Association for Medical Education. He is a board certified internist and a graduate of the University of Michigan Medical School.

W. Donald Weston, MD, *radiology and psychiatry professor, and dean from 1977-89 of the MSU College of Human Medicine,* has been named vice chancellor for health sciences at the University of West Virginia. As vice chancellor, he will direct three medical schools, two nursing schools, a dental school, a pharmacy school, and a nurse-midwife program, in the University's health sciences division.

Four Michigan physicians *are among 129 newly-named fellows of the American College of Radiology.* They are: **Fred E. Patterson, MD**, Jackson; **Darrel J. Rosen, MD**, Grand Rapids; **Henry L. Vanderkolk, MD**, Grand Rapids; and **Alkis P. Zingas, MD**, Detroit. Each were selected for their outstanding contributions to the field of radiology.

Raj Modi, MD, and Abdullah Raffee, MD, *both Flint specialists in medicine,* are newly-elected fellows of the American College of Physicians (ACP). Doctor Modi graduated from B.J. Medical College in 1972, and completed his residency at Hurley Medical Center in 1981. He is certified by the American Board of Internal Medicine. Doctor Raffee is a graduate of Royal College of Surgeons, Dublin, Ireland, and trained as an intern at Eben Donges Hospital in South Africa. He did his residency at Hurley Medical Center. Doctor Raffee is a member of the Genesee County Medical Society, Michigan State Medical Society, and the American College of Physicians.

Steven Stein, MD, *Ann Arbor,* is the newly-appointed director of the Gerontology Center of Excellence, Oakwood Health Services Corporation. Prior to joining Oakwood, Doctor Stein was an instructor of medicine at Harvard Medical School, Boston, Mass.

L. Edmond Eary, MD, *a recently retired Sparta family physician,* is the newly named 1991 Sparta Citizen of the Year by Sparta Masonic Lodge. Doctor Eary retired August 30 after 34 years as a doctor in the Sparta area. He received the "Family Physician of the Year" award in 1990 from the Michigan Academy of Family Physicians. In 1989 he was awarded the Plessner Award by the Michigan State Medical Society as the physician who best exemplifies the rural country doctor.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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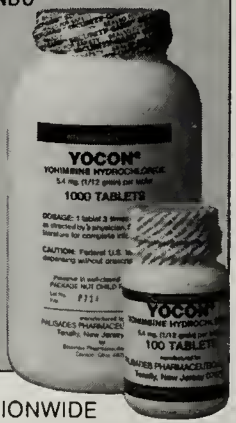

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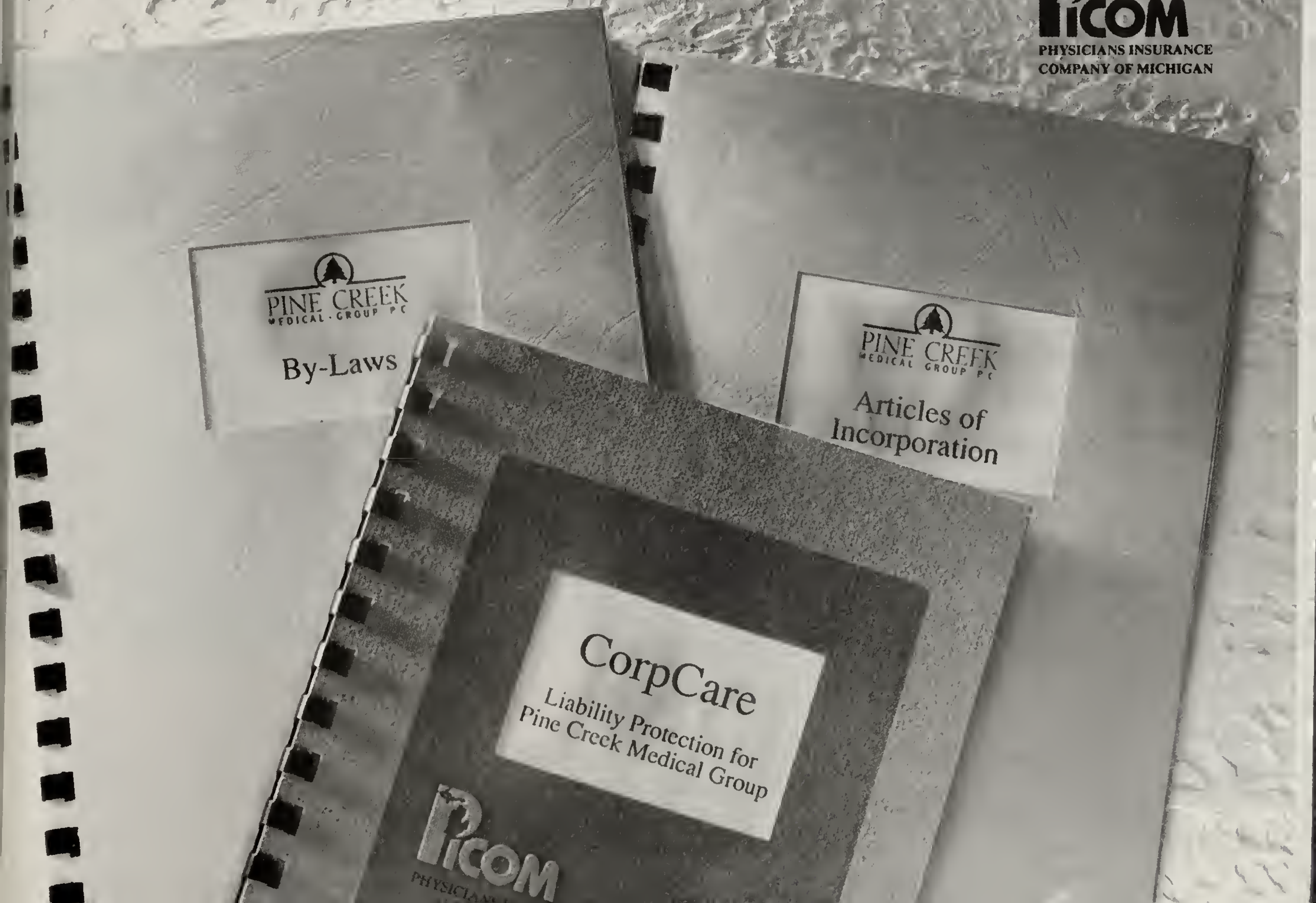
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As I like to mention to any non-member colleague, MSMS is the largest, most comprehensive, most effective organization in the state representing the interests of physicians and patients. It is also an organization which remains truly democratic.

If MSMS has taken a position with which you cannot agree, let us know through your District Board member, your House of Delegates representative, by letter or phone. MSMS represents more than 11,000 individual Michigan physicians, and I know from personal experience that you are never going to get 11,000 doctors to agree on every issue. MSMS membership is one of the best values I know of.

I would like to thank a few physicians who in the past year have spent a considerable amount of their personal time in recruitment and retention activities for MSMS and their county medical societies. Tama D. Abel, MD, and Hassan Amirikia, MD, were both acknowledged by the AMA for their outstanding recruitment efforts for the young physicians and hospital medical staff sections, respectively. Gilbert B. Bluhm, MD, chairman, Wayne County Medical Society Membership Committee, has worked tirelessly on behalf of WCMS and the state society in recruiting new members by coordinating a series of direct recruitment projects in several Detroit hospitals. These and many other physicians speak on a daily basis for MSMS. Their efforts are truly appreciated.

Medicine today is full of challenges and uncertainties. By working together, we can ensure a quality health care environment for our patients and our families. By remaining a member of your county, state and national medical societies, you provide a united voice to the many outside influences infringing on the current health care system. No single physician could buy the representation or the influence that our joint organizations have. It is our association — physicians working with other physicians — who maintain the integrity and high health care standards enjoyed in the United States today! ■

Dorothy Kahkonen, MD
Chairman,
MSMS *Committee on Membership*
Recruitment and Retention

Cover Story

MSMS SECTIONS A VITAL FORCE

MSMS membership sections are vital forces in determining the Society's programs and goals. The sections provide a forum and organization for medical students, residents, hospital medical staff members, young physicians and international medical graduates to channel their concerns into action.

All but the international medical graduates have national-level counterparts of their sections. The MSMS Section for International Medical Graduates is the first of its kind in the nation.

Each section operates as a subgroup of the MSMS House of Delegates, through which all requests for action must pass. The sections hold annual meetings in the spring, just prior to the MSMS House of Delegates meeting, when they pass resolutions for consideration by the MSMS delegates. (This year, for the first time, the sections will gather for a joint meeting March 14.)

Each section has a governing council and elects delegates and alternates to the MSMS House. Governing council chairmen are official guests at each MSMS Board meeting.

Following is a roundup of current section activities.

Medical Student Section

The MSMS Medical Student Section is very active on each medical school campus. Each campus provides a number of local community health projects and activities designed to acquaint medical students with the myriad of areas in which organized medicine is involved. For the medical student, the local student chapter serves as a critical resource, as well as a primary means by which students can influence the direction of organized medicine, and consequently, their future as one of its practitioners. Activity at the AMA Medical Student Section has been high, too. The MSMS Medical Student Section appreciates the financial support which MSMS provides so that medical students can participate first-hand in the AMA.

Following are the projects and activities that each medical school have developed over the past year.

■ The Michigan State University College of Human Medicine began last year with the semi-annual book coop sale. The sale allows students to purchase medical texts at reduced rates. Other activities include: the Med Student Mixer, sponsored by MSMS and held last year at the USA Cafe; a community health fair day; AIDS education efforts in the community; a series of risk management/medical malpractice seminars provided by MSMS and MPMLC; and a "pizza" lecture by Howard Brody, MD, MSU College of Human Medicine professor, on assisted suicide/euthanasia, also sponsored by MSMS. The MSU Medical Student Section will provide a number of these same activities during the 1991-92 school year.

■ At the Wayne State University School of Medicine a number of exciting projects were completed. The annual medical student dinner/talent show; the annual Christmas Party For Kids; a Mock Malpractice Trial; the Undergrad Outreach Program; Needlefest, a program that teaches students how to draw blood; and Health-O-Rama, a series of free clinics open to anyone interested in receiving a free medical work-up. The WSU Medical Student Section will again sponsor most of these projects in 1991-92 along with a new Teen Pregnancy Education Program. The program is designed to teach pregnant teens about pregnancy, childbirth and nutrition with the aim of decreasing Detroit's infant mortality rate.

■ The University of Michigan Medical School started off last year with the annual Ice Cream Social, followed up by the annual U-M Medical School logo sale on shirts-hats-stickers-rings, the book co-op, lectures on "The Sense of Community-The Physician and Social Policy;" "Minorities in Medicine;" and "The Medical Marriage," a program on health and anxiety reduction at a local children's center and our high school outreach program. U-M med students also participated in the AMA Leadership Conference and hope to do so again this year.

Section officers include: Roger J. Diegel, Wayne State University, chairman; Shabnum H. Sheikh, University of Michigan, vice chairman; and Sandra Brinker, Wayne State University, secretary.

Resident Physician Section

The MSMS Resident Physicians Section is working on innovative ideas to increase membership in the section. The Governing Council has developed a new application form for residents that will make the application process more straightforward. Chairman Mark W. Sawka, MD, and Vice Chairman Michael D. Chafty, MD, have been taking the proposed application to the county medical societies for approval. The Section also is planning a phonathon to recruit members after the new application is approved.

The Section monitored resident work hours legislation and participated in hearings held by the Senate Health Policy Committee, chaired by Senator John Kelly. Several resident physicians also testified before the Medical Liability Subcommittee of the Senate Judiciary Committee, chaired by Senator William Van Regenmorter. Among those residents was former section chairman A. Bradley Eisenbrey, MD, PhD. Resident physicians testified that they are extremely aware of the liability problem in Michigan and they are making their decisions on where to practice based on this knowledge.

The Section introduced a resolution to the MSMS House of Delegates in May, 1991. The resolution addressed the differing criteria for permanent licensure of allopathic versus osteopathic medical school graduates and asks that MSMS work with the appropriate agencies to ensure uniform licensing requirements. The resolution was referred to the Board for further study.

The Section also sent Fernando Gomez, MD, and Michael Chafty, MD, as delegates to the AMA House of Delegates meeting in Chicago. The delegates partipicated in the AMA Resident Physicians Section meeting and the meeting of the full House. At the Section meeting, they voted on resident work hours limitations and other resolutions affecting residents and patients.

Governing Council members are Mark W. Sawka, MD, chairman; Michael D. Chafty, MD, vice chairman; Atul Shah, MD, secretary/treasurer; Michael D. Chafty, MD, delegate; Eric Rudnick, MD, alternate delegate; and Fernando Gomez, MD, AMA delegate. ■

Hospital Medical Staff Section

The MSMS Hospital Medical Staff Section (HMSS), which has been active for over eight years, is now an integral component of MSMS activities. The HMSS held its Seventh Annual Meeting this past spring. John T. Kelly, MD, PhD, Director of Quality Assurance, AMA, spoke on "Practice Parameters: Key to Quality Advancement." Over 60 representatives and guests attended the meeting, including John C. Herrman, MD, New York State HMSS Chairman.

The main activity of the HMSS has been a series of presentations to hospital medical staffs throughout the state on important issues regarding hospital medical staff issues. The health care system is in a period of unprecedented changes. With these changes come points of disagreement between hospital executives and physicians. The Physicians Issues Presentations (PIPs) provide information concerning strategies for hospital/medical staff co-existence, and about important action that MSMS is engaged in on behalf of members. PIPs have been presented to the following hospital medical staffs: Annapolis Hospital; Bay Medical Center; Bronson Medical Center; Children's Hospital Detroit; Heritage Hospital; Mercy Memorial - Monroe; Munson Medical Center; and Northern Michigan Hospital. If you are interested in having a PIP at your hospital, contact F.B. "Tom" Plasman, Manager, Hospital Medical Staff Relations, at MSMS headquarters.

The HMSS continues to provide assistance to medical staff officers in undertaking the review and preparation of by-laws, membership and credentialling protocols, medical staff administration and other important issues unique to medical staff procedures.

Michigan physicians are also active at the AMA-HMSS, and a large contingent from Michigan is always present at the Interim meeting in December and the Annual meeting in June. Current Vice-Chairman of the AMA-HMSS is Peter A. Duhamel, MD, past chairman of the MSMS-HMSS. The Section is pleased to announce that Doctor Duhamel will seek election as chairman of the AMA-HMSS in June, 1992.

Members of the HMSS Governing Council include Krishna K. Sawhney, MD, Chairman; Edward J. Rutkowsky, MD, Vice-Chairman; B.L. Pederson, MD, Secretary; Robert G. Borchak, MD, Member At-Large; John H. McLaughlin, MD, Member At-Large; John A. Rupke, MD, Delegate; Harry L. Doerr, MD, Alternate Delegate and Peter A. Duhamel, MD, AMA-HMSS Vice-Chairman. ■

Young Physician Section

The Young Physician Section is now in its fourth year of operation and continues to be a dynamic voice in organized medicine. Michigan young physicians have been pleased with the opportunity for active involvement in MSMS and do believe their voices are being heard. Currently, 75 young physicians serve on various MSMS committees and several current committee chairmen began in the YPS.

In the past three years the YPS has introduced 35 resolutions to the MSMS House of Delegates and several to the AMA-YPS Assembly. The resolutions have covered a wide range of topics, such as adoption, animals in research, safe day care centers, Medicare reimbursement, professional liability, HIV testing, and several environmental issues.

The YPS is extremely proud of the formation of the MSMS Committee on Environmental Health and the recycling program initiated at MSMS headquarters as a result of resolutions presented to the MSMS House of Delegates from the YPS.

Current activities of the section include a regular newsletter to all delegates and alternates, a young physician survey and the development of a natural science ambassador project.

MSMS continues to provide seminars for the young physician: Starting Yourself In Medical Practice, How to Run a More Profitable Practice, and Estate Planning.

The MSMS-YPS continues to be active at the AMA level and appreciates the support that MSMS has provided for representation at the AMA-YPS Interim and Annual Assemblies. The AMA-YPS establishes an ongoing presence for young physicians, fosters awareness of their unique needs and concerns, and ensures the opportunities to address these needs and concerns. MSMS is allocated two delegates and two alternates to the AMA-YPS.

Plans are currently underway for the 4th Annual Meeting, March 14, 1992, at The Dearborn Inn, Dearborn. The YPS Governing Council has begun the appointment process for delegates and alternates. The Section also plans to conduct a statewide membership campaign in the near future.

Current members of the YPS Governing Council are: Tama D. Abel, MD, chairman; Karl J. Edelmann, MD, vice chairman; Kevin O'Brien, MD, secretary; Douglas L. Colberg, MD, delegate; Patrick J. Droste, MD, alternate delegate, and Sherry Viola, MD, and Timothy Wellemeyer, MD, members-at-large. ■

International Medical Graduates

In 1988, MSMS set an important precedent within organized medicine when it established the very first state Section for International Medical Graduates. The Section represents the interests of graduates of medical schools outside the US and Canada to the MSMS House of Delegates.

Already, the positive impact of this pioneer section is evident in Michigan and across the nation. Many needed changes to biased policy and procedure have been set in motion. Issues of longstanding importance to IMGs are now being discussed at levels where change is possible.

Several other state medical organizations have followed our lead, and the collective voices of International Medical Graduates are being heard. Issues being tackled include licensing, reciprocity, hospital staff privileges, and residency programs, as well as issues of interest to all physicians, such as professional liability and AIDS. Special focus groups discussions – to be held late this year and in early 1992 – will help determine priorities for the Section.

The MSMS IMG Section has accomplished several important inroads:

- ■ Changed Michigan licensing laws to require two years of training for licensure, as opposed to the previous three. The same is required of US graduates.
- ■ Changed the rules of reciprocity in Michigan, so that no further documentation is required of IMGs than of AMGs.
- ■ Begun development of a process to assist non-matched prospective residents in obtaining placement in unfilled Michigan positions following Match Day.
- ■ Established a formal mechanism to receive written grievances from Michigan IMGs who charge they have been discriminated against.
- ■ Gained representation on MSMS councils and committees, on residency review committees and the ACGME, and on AMA councils and committees.

Members of the MSMS IMG Governing Council are: AppaRao Mukkamala, MD, chairman; Samir Yahia, MD, vice chairman; Filiberto Cavazos, MD, secretary/treasurer; Orlando Sison, MD, and Jayant Shah, MD, members at large; Allan C. Brown, MD, delegate; Ada van Vloten, MD, alternate delegate; and Timothy B. Aiken, MD, and Demetrio Timban, MD, proctors. ■

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- Delta Dental Insurance
- Professional Liability insurance through MICHIGAN PHYSICIANS MUTUAL LIABILITY INSURANCE COMPANY
- Car lease programs through AVIS, BUDGET & HERTZ
- Group disability plans/life or accidental death insurance through STRATTON, CHEESEMAN & WALSH, INC.
- Practice Management Seminars
- Continuing Medical Education
- RECOVERY, INC. to help Physicians afflicted with chemical dependency
- Physician Legislative Network: involves physicians in the legislative and lobbying process
- Washington Visitation program: the exchange of ideas with members of the House and Senate
- Personal and professional financial planning, marketing and administration assistance, bill collection and billing services through the PHYSICIANS SERVICE GROUP

1866

The list above represents many of the tangible benefits of belonging to the Michigan State Medical Society and your county medical society. No single physician could buy the representation or the influences that organized medicine provides. Please share this information with a non-member. The battles waged against medicine can only be fought with the support of all physicians.

Michigan

DOCTORS POLITICAL ACTION COMMITTEE

MDPAC needs your financial support in order to contribute to the campaigns of candiates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

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- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

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Mitchell A. Rinek, MD, Chairman, MDPAC

Contributions to MDPAC are not deductible as charitable contributions for Federal income tax purposes. Copies of MDPAC reports are filed with the Federal Election Commission, Washington, D.C.

Don't Leave the Politics of Health Care Solely to the Politicians

By Joseph F. Boyle, MD

A Message from MDPAC

Following are excerpts from an article which appeared in the September, 1991, issue of *The Internist: Health Policy in Practice*. The article is well worth reading because it shows how important it is for physicians to become involved in the political process. It also addresses some of this year's key legislative issues. I encourage you to read it — and then make the decision to contribute to the Michigan Doctor's Political Action Committee (MDPAC). With the appropriate funds, MDPAC can be powerful — powerful enough to bring about meaningful tort reform. Please consider making a contribution to the MDPAC today. For more information, contact Sandra Bitonti at MSMS.

Mitchell A. Rinek, MD
Chairman, MDPAC

It's that time of year again — time for the annual campaign contribution solicitation dance. Even though this is an off-election year, the invitations keep pouring in — from Republicans and Democrats, the parties and the candidates — requesting our presence at receptions, breakfasts, meet-the-candidate soirees and so forth. (And don't forget to bring money, of course!)

In presidential politics, it generally is conceded that George Bush will be the Republican candidate. Absent a total collapse of the economy, a major global gaffe or some as-yet-to-be-uncovered scandal involving Mr. Bush, the Democrats will be reduced to fielding a candidate purely for show — either a sacrificial lamb or someone trying to stake out dibs on the top spot for the 1996 ticket.

For other offices, neither party has a sure thing, since the public seems disenchanted with both of them. The Democrats do have majorities in both the House and the Senate, and it appears likely that they will maintain that dominance.

Blind loyalty?

It is also conceded that most physicians — if they vote at all (fewer than 50 percent are even registered) — will go Republican. I must confess, I am one of those — a physician and a Republican. This total predictability of physician fealties will be taken for granted by Republicans — as it has been by Republican office-holders for millennia — and will be rewarded by Republican officials who, once elected, would never dream of seeming to cater to the wishes of this privileged interest group. After all, most of them don't vote. Even fewer ever become involved in the political process — much less contribute time or money.

This blind physician loyalty seems strange indeed given our current political climate, the issues at stake, and how medicine and health care in this country have been faring under a succession of Republican administrations.

Let's get moving...now

In the past 12 months, physicians have inundated Congress and the administration with many thousands of letters protesting various actions — the CLIA regulations, the Medicare fee schedule, the gag rule for family planning clinics. It is too early to know what the outcome of this activity will be. But it is predictable that until the next crisis, physicians will go back to their consultation rooms, surgical suites and laboratories and forget about legislation and legislators.

A recent article in *Time* asks if all of this activity might signal a new era of medical activism. "Probably not," *Time* says. "Most doctors would prefer to leave politics to the politicians." *Time* is probably right. But now is the moment to change all of that.

Physicians should seek the opportunity to meet with their legislators at the federal and state levels... Participate in the election process, and, yes, bring financial support when asked.

It doesn't matter which party you belong to or which party has fielded the candidates. Once elected, they all vote on your future and the future of medical care in this country. Do not allow blind party loyalties of years or even generations bind you to one side or the other.

As things stand now, the political environment does not appear likely to improve anytime soon. Without physician involvement in the politics of health care, that time will be never. ■

Doctor Boyle is executive vice president of the American Society of Internal Medicine.

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Learning from the "United Way"

By Billy Ben Baumann, MD
and Frank B. Walker, MD

Doctor Baumann

Doctor Walker

Years ago, individual community service organizations would each have their own fundraising campaign which sometimes resulted in several groups soliciting contributions at the same time. Finally, someone realized that by combining their efforts, both the organizations and the public could benefit. They called this cooperative "United Way."

In many ways, we in organized medicine are trying to achieve the same objective by combining our resources to serve the many. This need is far greater in medicine today than it has ever been and more physicians are realizing this.

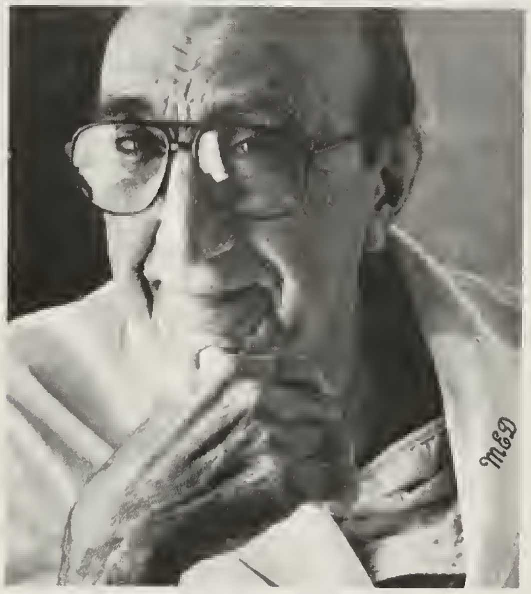
Physicians are facing an increasing number of problem which require action, if we are to preserve any control over our future and offer the best medical care for our patients. As individuals we are relatively ineffective, but when individuals have common goals and their voices repeat similar themes, they can become very effective. Combined into organizations with coordinated leadership, they can speak with one strong voice and extend influence into the legislatures, business and government agencies, and the news media.

We must convince our nonmember colleagues that this united approach is the only way we can hope to deal with all the changing events in medicine, and only by utilizing our combined talents and resources can we preserve our professional standards. As members, we know how well the system works but we need more members and more financial resources to have the necessary clout. It is our responsibility to promote this idea to nonmembers and persuade them to join us in making this a truly united body of physicians.

The AMA is launching a campaign to recruit more of our colleagues in membership to help all of us meet the challenges of medicine during the coming months and years. We hope that each member will do his or her share to encourage a nonmember to join with us so that with the strength of increased numbers and financial support we can speak with a more powerful voice wherever it is needed. Let us not only become united in numbers but in spirit. ■

Doctor Baumann is chairman of the Michigan Delegation to the AMA an serves as MSMS treasurer. Doctor Walker is a member of the AMA Board of Trustees and is chairman of the AMA Finance Committee.

Join
Dr. DeBakey.



Join
The AMA.

"As a member of the AMA, I'm part of an organization that's involved in my life work, and through it, I feel I have a relationship with other doctors."

Join Dr. Michael E. DeBakey, Chancellor and Chairman, Department of Surgery, Baylor College of Medicine, in the American Medical Association. Call this toll-free number now.

1-800-AMA-3211

American
Medical
Association

MD-2000

AMA Campaign to Strengthen Bond Between Physicians and Patients

In August the AMA began a series of ads speaking directly to 73 million Americans. The physicians pictured in the ads — which are currently running in *Time*, *Newsweek*, and U.S. *News and World Report* — present profiles of AMA physicians making a difference. AMA Executive Vice President, James S. Todd, MD explained that "these champions of professionalism are upholding the highest standards of our profession, helping those most in need."

The four AMA member physicians profiled in the campaign are:

- Kenneth R. Haller, MD, a pediatrician in East St. Louis, America's fourth poorest city.
- Aliza Lifshitz, MD, an internist, one of the first Hispanic physicians to become involved in the AIDS problem in Los Angeles.
- Kevin J. Fullin, MD, a cardiologist, who helps support a battered women's shelter in Kenosha, Wisconsin.
- Paul A. Volberding, MD, devoted to research to extend the lives and ease the suffering of AIDS victims in San Francisco.

The goal of these ads is to demonstrate to members, non-members and the public that the AMA is meeting its obligation as advocates of the medical profession. They demonstrate to all the quality of physician that belongs to the AMA.

The campaign put the spotlight on the AMA's Principles of Medical Ethics through the work of these four doctors (reprinted below). Doctor Lifshitz' work epitomizes her belief in the principles: "There are two standards by which I run my practice everyday — to inform the public about health care and to participate directly in community improvement."

The physicians were selected on the basis of their efforts with one of the public health issues on the AMA's health care agenda: interpersonal violence, AIDS research and treatment, care of the underserved, substance abuse and biomedical research.

Each profile follows a similar format. Starting with each doctor's personal agenda, they look at the larger public health issue, then provide an AMA resource for information on the topic.

Collateral ads, focusing on these four physicians' reasons for joining the American Medical Association, will appear concurrently in leading medical journals, including the *New England Journal of Medicine*, *Medical Economics*, the *Journal of the American Medical Association*, AM *News* and the various medical specialty *Archives*.

Also under development are office displays and brochures that explain why physicians join the American Medical Association. Entitled, "Why I Belong," they are available without charge to AMA member physicians responding to coupons in the ads.

The ads will also provide AMA non-members a vehicle to join the more-than-quarter-million-member organization.

While the AMA's efforts often benefit member and non-member physicians alike, it is the support of the AMA's members who have made this communications program possible and who serve to benefit most from this campaign. Only a national effort can succeed in telling the story of all physicians.

"To be an AMA doctor is to be a special kind of doctor," says John J. Ring, MD, AMA president, "the kind of doctor who sacrifices for patients' good, the kind of doctor all Americans should want their doctor to be." ■

A Message from the MSMS Auxiliary

Physicians' Spouses Care

By Virginia Mehregan

Just as quality health care has always been the top priority of the Michigan State Medical Society, so has assisting the MSMS in achieving this goal been the commitment of the Michigan State Medical Society Auxiliary. The Auxiliary is a group of physicians' spouses, both men and women, who care deeply about the quality of life of all people and who care about the practice of medicine.

County Auxilians, working with their medical societies, are involved in a wide variety of health related projects. Just to mention a few of those projects, they have collected drug samples for the needy, worked with schools in preventing drug abuse, spread the word about AIDS, helped victims of domestic abuse, and presented programs on nutrition and bike safety to elementary school children. Auxilians have raised money at local fundraisers for health scholarships and community needs. They have sponsored blood drives, walk-a-thons, health fairs, and screening programs, always giving of themselves to help others.

Last year, the AMA Auxiliary raised $2.4 million dollars nationwide for the AMA's Education and Research Foundation. In Michigan, Auxilians raised over $40,000 which was donated to the medical schools of the University of Michigan, Wayne State University, and Michigan State University to be used for medical student aid and the development of medical school programs.

This past summer, Auxilians helped the AMA and MSMS inform legislators about how physicians and patients are affected by the Resource Based Relative Value Scale, which was recently implemented under Medicare. Whenever an important legislative issue arises, the Auxilians are there with "Phone Banks" to urge physicians to contact key members of Congress to ensure sound health care legislation. Auxiliary and MSMS members continue to show the video entitled "Medicine in Jeopardy" to non medical audiences throughout the state to increase public awareness of the medical liability crisis.

Auxilians also care about each other. The Auxiliary encourages fellowship among physicians' families and support of each other in times of personal difficulties.

So, physician, if there is a spouse in your house, male or female, please encourage him or her to join our outstanding group of caring people, or surprise that spouse with a gift membership in the Auxiliary. Yes, *physicians' spouses care*, and we need each and every one of them.

For Auxiliary membership information, contact your county medical society auxiliary, or Virginia Mehregan, MSMSA Membership Chairman, c/o Dawn Reha, P.O. Box 950, East Lansing, MI 48823-0950.

Virginia Mehregan is MSMSA vice president and membership chairman.

AMA

Principles of Medical Ethics

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals and to self. The following Principles adopted by the American Medical Association are not laws but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals and shall safeguard patient confidence within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of the other health professionals when indicated.

VI. A physician shall, in the provisions of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

MICHIGAN STATE MEDICAL SOCIETY (MSMS

House of Delegates

281 Total Delegates
244 County Delegates
63 Delegates from Wayne County
RATIO: 1 Delegate/50 Members
1 Hospital Medical Staff Section Delegate
1 Young Physicians Section Delegate
1 International Graduate Delegate
3 Medical Student Delegates
1 Resident Physician Delegate
34 Specialty Society Delegates

- Meets once a year (April/May)
- Elects Officers, Directors, AMA Delegates/Alternate Delegates
- Receives and acts on reports from directors, committees and 8 reference committees

Board of Directors

8 Officers
Chair
Vice Chair
28 District Directors

- Meets throughout the year
- Policy-making body between meetings of the House of Delegates
- Acts upon reports from the officers and committees

MSMS Sections

- Medical Student Section
- Resident Physician Section
- Hospital Medical Staff Section
- Young Physicians Section
- International Medical Graduates Section

Reference Committees

Committee A - Medical Care Delivery
Committee B - Legislation
Committee C - Internal Affairs & Public Service
Committee D - Professional Liability
Committee E - Public Health & Miscellaneous
Committee F - Medical Education & Misc.
Committee on Constitution & Bylaws
Committee on Ways and Means

MSMS Committees

- Aging
- Awards
- Bioethics
- Liaison with BCBSM
- Communications and Professional Relations
- CME Accreditation
- Federal Legislation
- Impaired Physician Program
- State Legislation & Regulations
- Advisory Committee on Medical Economics
- Membership Recruitment and Retention
- Medical Licensure & Discipline
- Liaison Committee MDPH
- Maternal & Perinatal Health
- Liaison Committee with Medicaid
- Liaison Committee with MPRO
- Task Force Professional Liability
- MSMS/MHA Liaison Committee
- Interprofessional Liaison Committee with State Bar of MI
- Concerns of Women Physicians
- Task Force on Environment & Health
- Task Force on Rural Health Care
- Planning Committee for MSMS Annual Scientific Meeting
- CME Programming
- Task Force on AIDS Education
- MSMS/MPMLC Risk Management Committee

AMERICAN MEDICAL ASSOCIATION (AMA)

House of Delegates

442 Total Delegates
361 State Delegates
12 Delegates from Michigan
Ratio: 1 Delegate /1,000 Members
81 Specialty Delegates

- Meets twice a year (June & December)
- Overall policy-making body
- Elects Officers
- Elects Trustees
- Elects Council Members
- Receives and acts on reports from Trustees, Councils and 9 reference committees

10 Branches of Federal Services, medical schools, medical students, resident physicians, young physicians and HMSS

AMA Sections

Medical Student Section
Resident Section
Hospital Medical Staff Section
Young Physician Section
Medical School Section

Board of Trustees

President
President-elect
Immediate Past President
12 Elected Board Members
1 Resident Physician Member
1 Medical Student Member

- Meets throughout the year
- Policy-making body between meetings of the House of Delegates
- Reports back to the House of Delegates

AMA Departments

- Senior Management
- Office of General Counsel
- Financial Services
- Medical Education & Science
- Medical Education
- Science and Technology
- Science Information
- Public Affairs
- Health Service Policy
- Professional Relations and Membership
- Marketing
- Human Resources
- Administrative Services
- Public and Professional Communications
- Publishing

AMA Councils

8 Constitution and Bylaws
- Medical Education
- Long Range Planning
- Scientific Affairs
- Legislation
- Ethical and Judicial Affairs
- Medical Service

Michigan Physicians Holding Positions in AMA

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American Medical Association

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Cover Story

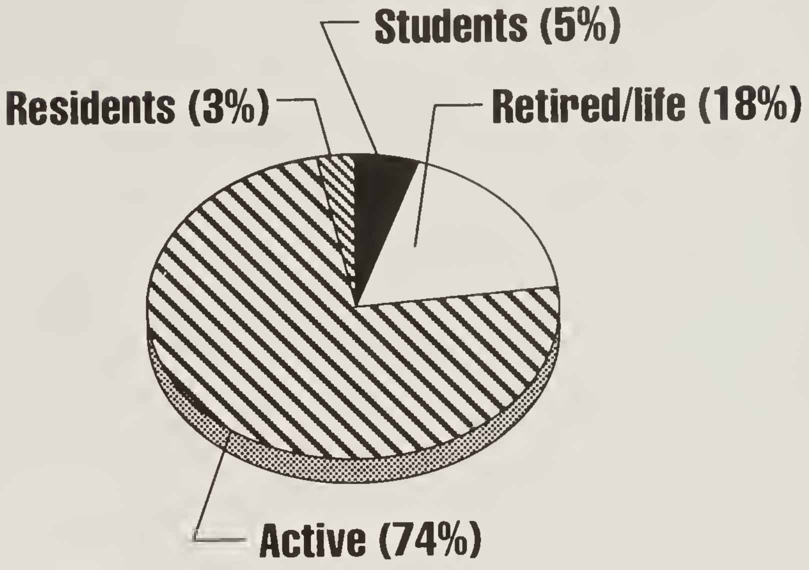
MSMS
DEMOGRAPHIC INFORMATION

The following data represent a picture of current MSMS membership. The charts and graphs include information regarding the following:

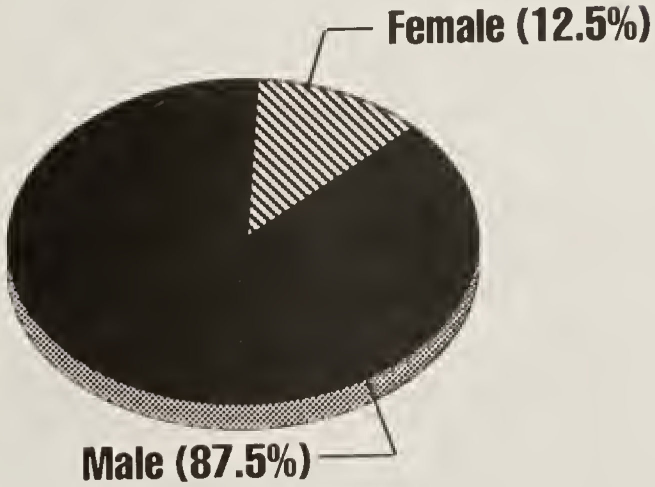
- Membership by gender
- Membership distribution by class
- International medical graduates

The Department of Membership Recruitment and Retention presents this data for your information. If you have any questions regarding the information, please contact MSMS.

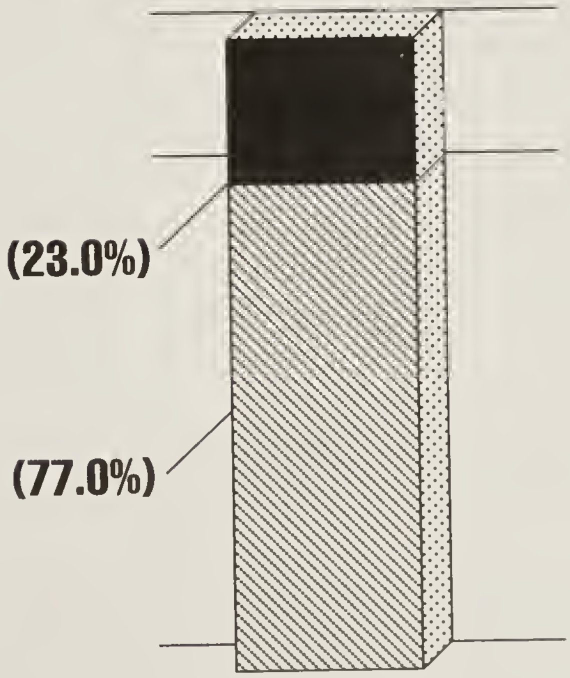
Membership Distribution by Class



Membership Distribution by Gender



International Medical Graduates



WHOM TO CALL AT MSMS HEADQUARTERS

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William E. Madigan

Assistant Director
Kevin A. Kelly

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AMA Delegation	Judy Marr
Annual Scientific Meeting Program	Lori Randall
Arbitration	Dan Farhat, Sandra Bitonti
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Uses the expanded power of a hard disk-equipped personal computer to fully automate billing and business management capabilities:

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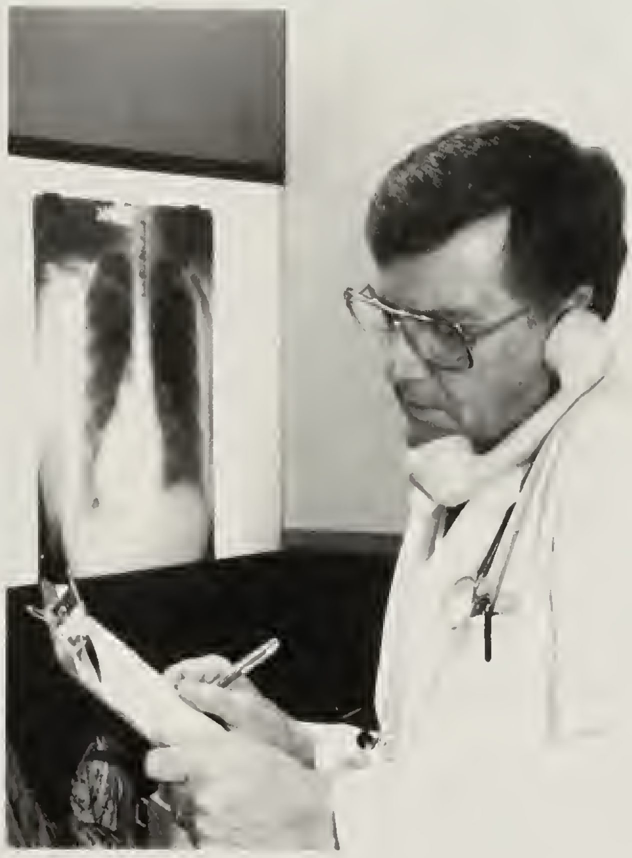

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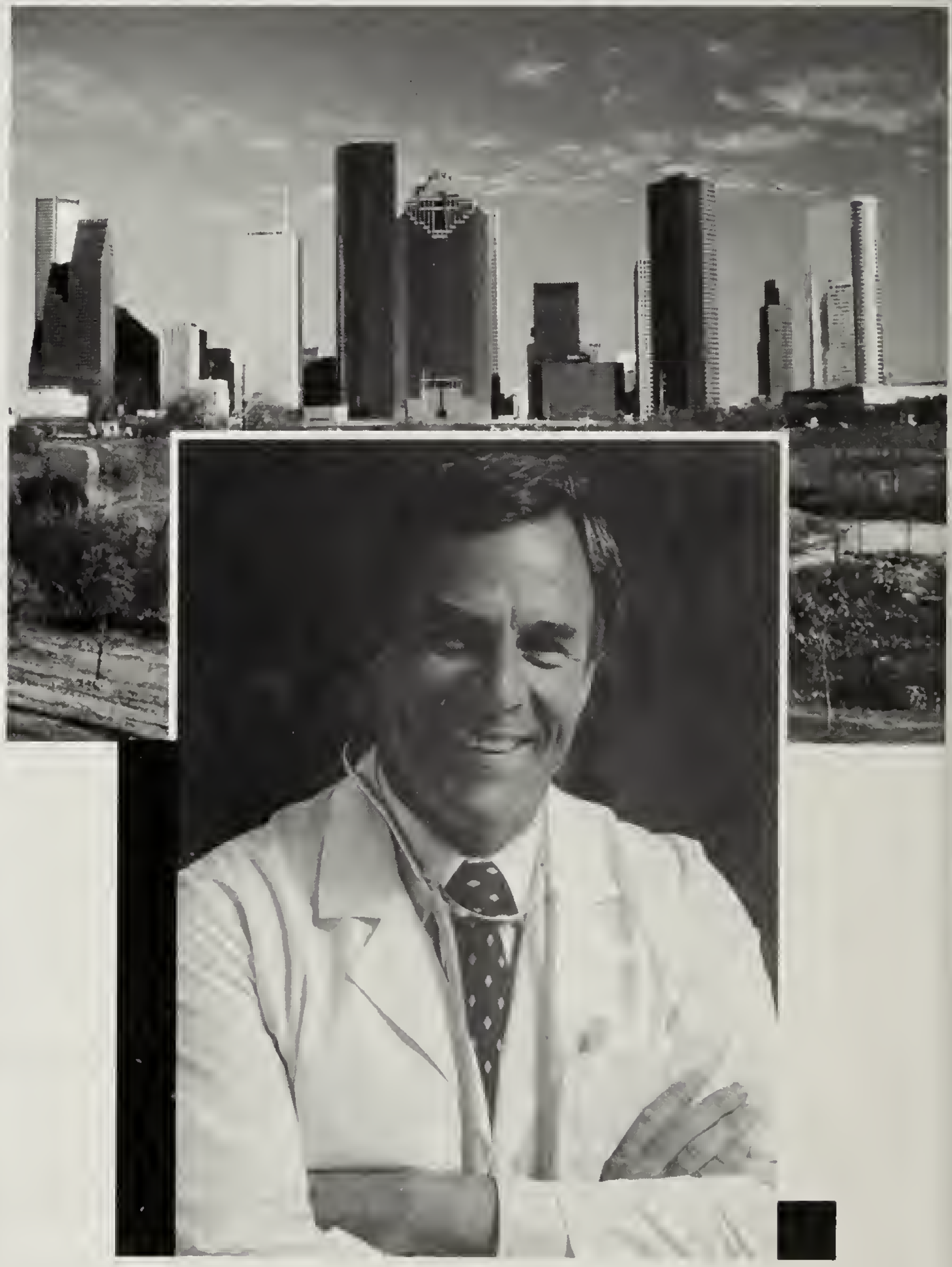

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Medicare Fraud & Abuse Safe Harbor Regulations

By Paul M. Shirilla and Patrick J. Haddad

The following is printed verbatim from the September 1991 issue of Health Law Report, a publication of Kerr Russell and Weber, Detroit. The law firm provides legal counsel to MSMS.

The final Medicare Fraud and Abuse Safe Harbor Regulations were issued by the Department of Health and Human Services (HHS) on July 29, 1991. The regulations exempt 11 health care business practices from prosecution under the Medicare anti-kickback statute.

The 11 exemptions or safe harbors apply to the following business practices: investment interests, space rental, equipment rental, management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, and waiver of beneficiary deductible and coinsurance.

Investment interests

The final regulations have tightened the standards for investment interests. Under the adopted regulations, no more than 40 percent of the investors in partnerships and joint ventures can be in a position to make or influence referrals. No more than 40 percent of revenues can be generated by investor referrals. The cap under the proposed regulations was 50 percent.

Any investor doing business with a health care entity will be included in the 40 percent cap. Investors in a position to make or influence referrals (which includes physicians, hospitals, nursing homes and other entities capable of influencing referrals), but who do not actually do so, would also be included unless they state in writing that they will not refer to the entity.

Other provisions of the investment safe harbor include:

- investment terms must be the same for referring and non-referring investors;
- terms cannot depend on the investor's past or expected referrals;
- investors cannot be required to make referrals to stay on as investors;
- the entity cannot loan money to the investor to make the investment; and
- payments to investors must be directly proportional to the amount of capital invested.

Management contracts

The investment interests safe harbor for large publicly traded entities has also been restricted. Qualified entities must now have $50 million in "undepreciated, non tangible assets." The regulations specifically exclude all tangible assets, including the corporation's valuation of its name recognition, stock and good will.

Space, equipment rentals

The safe harbors for space and equipment rentals and for personal services and management contracts have similar requirements. Agreements must be in writing, signed by the contracting parties and be for at least one year. Short term agreements are not protected. Lease agreements must clearly describe the covered premises or equipment. Other agreements must set out the services provided. Per-use or per-procedure payments are not covered by the safe harbor.

Sale of practice

The safe harbor for the sale of a medical practice applies only to sales to other practitioners and not to hospitals. To fall within this safe harbor, the sale must be completed within one year of the agreement date. Beginning one year after the agreement date, the selling practitioner must not be in a position to make referrals to or otherwise generate business for the purchasing physician who receives Medicare or Medicaid payments.

Referral services

Under the referral services safe harbor, all qualified individuals must be accepted. Charges to participating practitioners or providers must be based solely on operating costs, not referrals. Registrants cannot be told how to furnish professional services.

Warranties

Under the warranty safe harbor, practitioners or providers must report any price reductions obtained

Continued on page 41

Continued from previous page

as part of the warranty when filing federal or state cost reports or claims for payment. Manufacturers or suppliers must fully and accurately state price reductions or free items on the buyer's invoice.

Discounts

Price reductions on arm's-length transactions for goods or services that are related to the original goods or services are protected under the discount safe harbor. Numerous common discounting practices are not protected, such as cash payments, bundled purchase arrangements, reductions in prices applicable to one or more payors but not to Medicare/Medicaid, and price cuts to beneficiaries.

Employees

Employee safe harbors provide that wages paid to practitioners or other Medicare/Medicaid providers are permissible if the employee has a *bona fide* employment relationship with the employer. Independent contractors are not protected under this safe harbor. Some independent contractors, however, could fall under the personal services/management contract safe harbor.

Group purchasing

Group purchasing organizations are protected if they have written agreements with each individual or entity to whom goods or services are furnished. These agreements must state that fees from participating vendors do not exceed three percent (3 percent) of items sold to affiliated purchasers.

Co-insurance, deductible waiver

The safe harbor for waiver of co-insurance and deductible is limited to protection of such waivers by hospitals for inpatient services and by community health centers for Maternal and Child Health and Medicaid services. Hospitals cannot claim the waived costs on their cost reports and they must offer the waiver to all Medicare beneficiaries. ■

The authors are attorneys with Kerr, Russell and Weber, Detroit.

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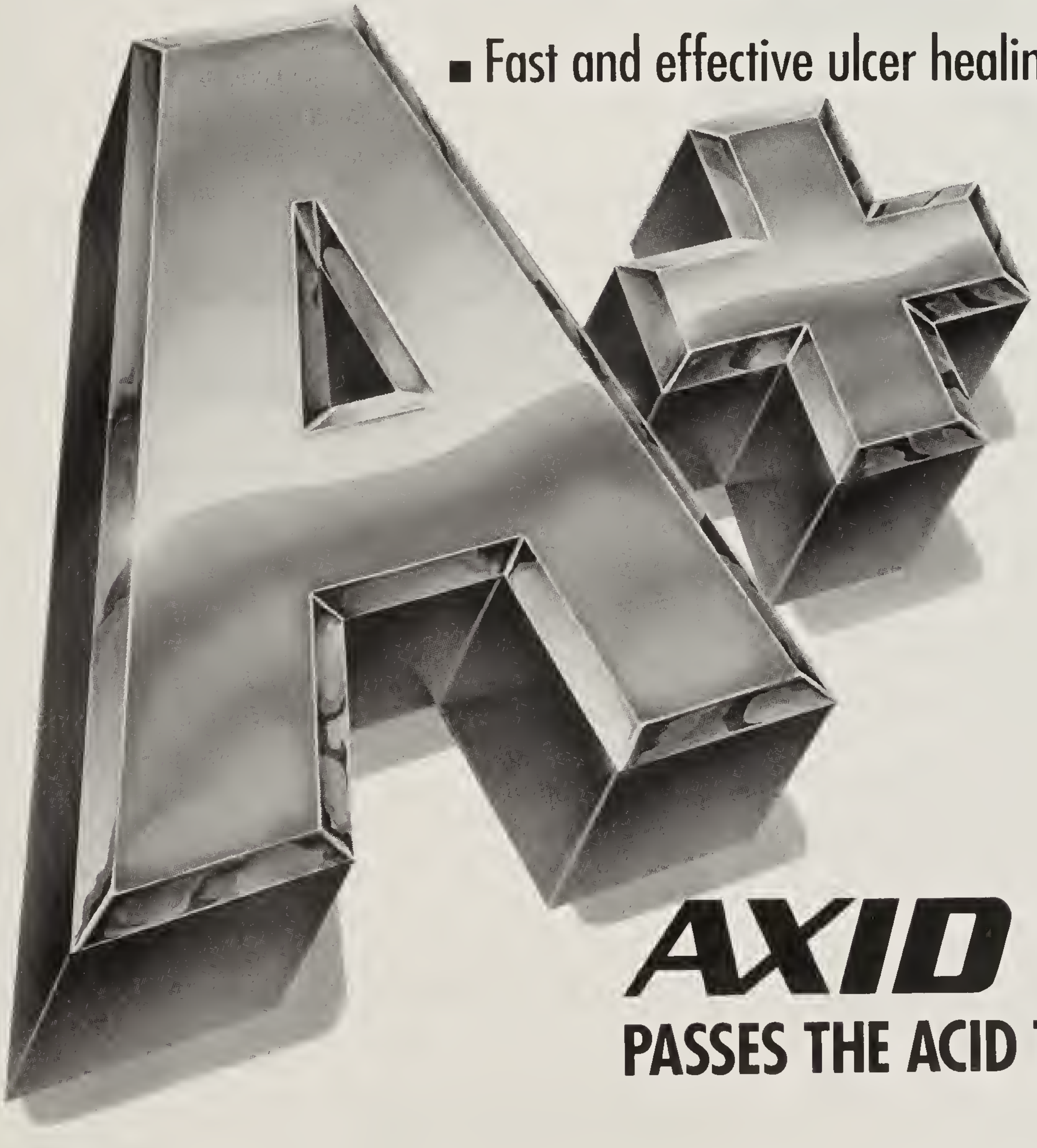

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See adjacent page for references and brief summary of prescribing information.

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Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer* – for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother

Pediatric Use – Safety and effectiveness in children have not been established

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs Rare cases of thrombocytopenic purpura have been reported

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported Eosinophilia, fever, and nausea related to nizatidine have been reported

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References
1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987,22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987,22(suppl 136):47-55
4. *Am J Gastroenterol* 1989,84.769-774

NZ-2943-B-149347

Additional information available to the profession on request

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: William J. Alt, MD, 101 Norton Medical Center, Muskegon, MI 49444-3788
Action, Date Taken: Probation 1 year; June 19, 1991, Fined - $1,000
Reason: Negligence and Incompetency

Name: Richard Paul Capriccioso, MD, 2800 Hunter Heights, West Bloomfield, MI 48324
Action, Date Taken: License Summarily Suspended; May 15, 1991
Reason: Negligence and Incompetency

Name: Jesse Wendell Castleberry, MD, 12404 Summerport Lane, Windermere, FL 34786
Action, Date Taken: Probation 1 year; May 15, 1991
Reason: N/A

Name: Allan G. Clague, MD, 5305 E. Huron River Dr., Suite 1B70, Ypsilanti, MI 48197
Action, Date Taken: Licensee Summarily Suspended; July 29, 1991
Reason: Drug Related

Name: Bruce Dawson, MD, 2753 Lancaster Rd., Granville, Ohio 43023
Action, Date Taken: License Denied; May 29, 1991
Reason: Lack of Good Moral Character

Name: Mehmet Kusun Kasal, MD, 10 Windtree Lane, Winter Garden, FL 34787
Action, Date Taken: Reinstatement Denied; May 30, 1991

Name: John Lefevre, DO, 1200 River Valley Dr., Apt. 4, Flint, MI 48532
Action, Date Taken: Probation 2 years; July 8, 1991
Reason: Mental-Physical Condition

Name: Herbert L. Malinoff, MD, 1140 Martin Place, Ann Arbor, MI 48104
Action, Date Taken: License Suspended; May 15, 1991, 13 months commencing on April 18, 1990. Limited License 1 year. Probation 1 year; commencing on May 18, 1991, Fined $5,000.
Reason: Criminal Conviction

Name: David Anthony Vila, MD, 1526 Bay Street #5, Santa Monica, CA 90405
Action, Date Taken: Reinstated, Limited License; August 1, 1991

Name: George C. Ramsay, MD, Route #4, Box 412, Gadsden, AL 35901
Action, Date Taken: Reinstated, Limited License, Upon compliance with current medical educational requirements; August 1, 1991

Name: David B. Witte, MD, 16637 M-140, South Haven, MI 49090
Action, Date Taken: Fined $1,000; May 15, 1991
Reason: N/A

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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1934 Fox Fire Ct.
Bloomfield Hills 48013

Joseph W. Aquilina, MD U
3406 Davenport
Saginaw 48602

Pratap K. Aravapalli, MD AN
G-1173 N. Ballenger Hwy.
#203
Flint 48504

Manohar L. Atri, MD N/IM
1447 N. Harrison
Saginaw 48602

David K. Austin, MD AN
300 Warwick Drive
Alma 48801

Kirk G. Banerian, MD R
G-3239 Beecher Rd. Suite F
Flint 48532

Ronald C. Barry, MD PS/GS
4705 Towne Centre #303
Saginaw 48504

Francis A. Bartek, MD OBG
1201 W. Oakland #221
Lansing 48915

Ricardo Bartelme, MD FP
9477 N. Territorial Rd.
Dexter 48130

Javaid M. Bashir, MD IM/FP
505 Keefer Dr
Albion 49224

Lawrence A. Bauss, MD AN
502 Bronson Medical Ctr.
Kalamazoo 49007

Debra K. Beard, MD IM
1900 Wealthy St. #150
Grand Rapids 49506

Boris M. Beckert, MD FP
1414 W. Fair Ave. #36
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Mary Ellen Benzik, MD FP
265 Fremont St
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Continued on following page

Henry Ford
Medical Association presents

"Performing Arts Medicine"

CME and Social Program/Dinner
Friday, November 15, 1991
3:00 p.m.
Detroit Institute of Arts

This program is open to all Henry Ford Medical Association members and includes a continuing medical education program (3.0 credit hours) on "Performing Arts Medicine", gallery tours for participants and guests, a recital by Oakland University vocalists Edith Diggory and John Paul White, and dinner .

FOR MORE INFORMATION, CALL 313-876-7333.

PROGRAM

The How and Why of Performing Arts Medicine
Michael S. Benninger, M.D., Otolaryngology, Henry Ford Hospital

The Care of the Professional Voice
Barbara H. Jacobson, Ph.D., Speech and Language Pathology, Henry Ford Hospital

The Care of the Dancer
Patricia A. Kolowich, M.D., Center for Athletic Medicine, Henry Ford Hospital

Performance Anxiety
Allan B. De Horn, Ph.D., Psychiatry, Henry Ford Hospital

The Care of the Instrumentalist
Gary Chodoroff, M.D., Private practice, Physical Medicine & Rehabilitation; Adjunct staff, Neurosurgery, Henry Ford Hospital

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Continued on page 44

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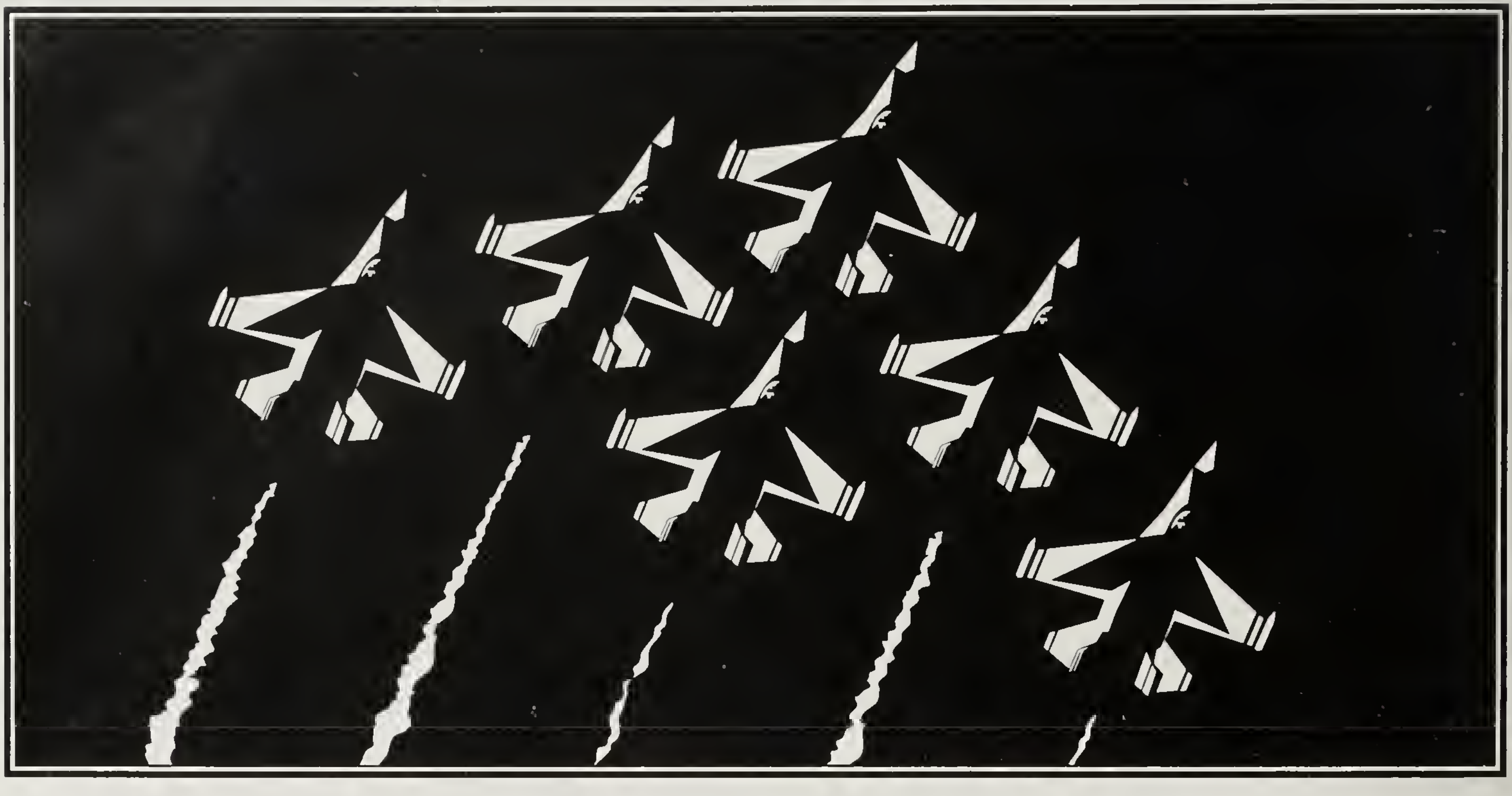

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CBC

MEETINGS

MSMS Meetings

November

12-14, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, MI. Over 50 courses offered. Contact the MSMS Office of Physician Education, (517) 337-1351 for a complete meeting program.

Michigan Specialty Society Meetings

November

7, On Freud's Adolescence: Freud, Gisela, Silberstein and the Repudiation of Feminity, Ann Arbor, MI. Contact: (313) 557-8633.

16, Seventeenth Annual Symposium, "Improving Clinical Skills: Lessons from Longer Psychoanalytic Treatments." Contact: Michigan Psychoanalytic Society, 16310 West Twelve Mile Rd., Suite 204, Southfield, MI 48076, (313) 559-5855 or (313) 557-8633.

December

7, Cries and Whispers, Royal Oak, MI. Contact: (313) 557-8633.

February

11-12, 1991 Director's Conference Healthy Communities: Expanding Partnerships for Chronic Disease Prevention. Contact: Michigan Department of Public Health, (517) 335-8389.

National Specialty Society Meetings

December

15-18, Scientific Conference on the Application of Magnetic Resonance to the Cardiovascular System. Contact: American Heart Association, Resonance to the Cariovascular System, Scientific and Corporate Meetings, 7272 Greenville Ave., Dallas, TX 75231-4596.

January

16-18, American Academy of Pain Medicine's 1991 Annual Conference. Contact: Carol Endicott, (708) 966-9510.

Other Meetings

November

6, Crohn's & Colitis Foundation of America, Ingham Medical Center, Lansing, MI. Contact: Linda Rockey (517) 676-4870 or Floyd Barrows (517) 669-5314.

December

4, Crohn's & Colitis Foundation of America, Ingham Medical Center, Lansing, MI. Contact: Linda Rockey (517) 676-4870 or Floyd Barrows (517) 669-5314.

12, Update in Cardiovascular Disease 1991, Toledo, OH. Contact: Susan Hahn, (419) 381-4237. ■

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

November

Oct. 31-Nov. 2, 21st Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center, Grand Rapids, Michigan. **Sponsors:** International Federation of Societies for Surgery of the Hand, Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Genevieve de Groot Swanson, MD, Blodgett Professional Bldg, 1900 Wealthy, SE, Suite #290, Grand Rapids, MI 49506, (616) 774-0440. **Approved for:** 18 hours Category I Credit.

5, Client Services Through Clinical Excellence for Persons with Developmental Disabilities. Location: Gilmore Center for Health Education, Kalamazoo, Michigan. **Sponsors:** Michigan Department of Mental Health, John E. Fetzer Institute, Inc., Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, Director, CME, MSU/KCMS, 1535 Gull Rd., Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 5.5 hours Category I Credit.

6, 5th Annual HFH Nutrition Symposium: Contemporary Issues in Nutrition with Emphasis on Minority & Urban Populations. Location: Hotel St. Regis, Detroit, Michigan. **Sponsors:** Henry Ford Hospital, Office of Continuing Medical Education. **Contact:** Henry Ford Hospital, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689, (313) 876-3073. **Approved for:** 6.5 hours Category I Credit.

7-8, Selected Topics Clinical Nutrition. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and The College of Pharmacy. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 936-9800. **Approved for:** 12 hours Category I Credit.

Continued on following page

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9, Every Doc's Pediatric Dermatology III. Location: Ritz-Carlton Hotel, Dearborn, Michigan. **Sponsors:** Henry Ford Hospital, Office of Continuing Education. **Contact:** Henry Ford Hospital, Office of Continuing Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689, (313) 876-3073. **Approved for:** 6.5 hours Category I Credit.

12, Medical Marriage: Issues of Effective Communication. Location: Kalamazoo Country Club, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, Director, CME, MSU/KCMS, 1535 Gull Road, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 2 hours Category I Credit.

13, Taking Charge in Staff Development. Location: Holiday Inn, Flint, Michigan. **Sponsors:** Michigan Nurses Association Continuing Education Council. **Contact:** Michigan Nurses Association, 2310 Jolly Oak Road, Okemos, MI 48864. **Approved for:** 6.6 hours Category I Credit.

14-15, Advanced Pediatric Life Support Course. Location: Children's Hospital, Detroit, Michigan. **Sponsors:** American Academy of Pediatrics and Michigan Chapter of the American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Executive Director, 500 Lansing Rd., Charlotte, MI 48813, (517) 645-8050. **Approved for:** 15 hours Category I Credit.

16, Current Concepts in Biliary Disease. Location: Novi Hilton Hotel, 21111 Haggerty Road, Novi, Michigan. **Sponsors:** Wayne State University School of Medicine, Department of Internal Medicine Division of Gastroenterology, Detroit Gastroenterology Society. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 4 hours Category I Credit.

16, Seventeenth Annual Symposium, Improving Clinical Skills: Lessons from Longer Psychoanalytic Treatments. Location: Michigan Psychoanalytic Society, Southfield, Michigan. **Sponsors:** Michigan Psychoanalytic Society. **Contact:** Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076, (313) 559-5855. **Approved for:** 2 hours Category I Credit.

Continued on page 51

PHYSICIAN OPPORTUNITY

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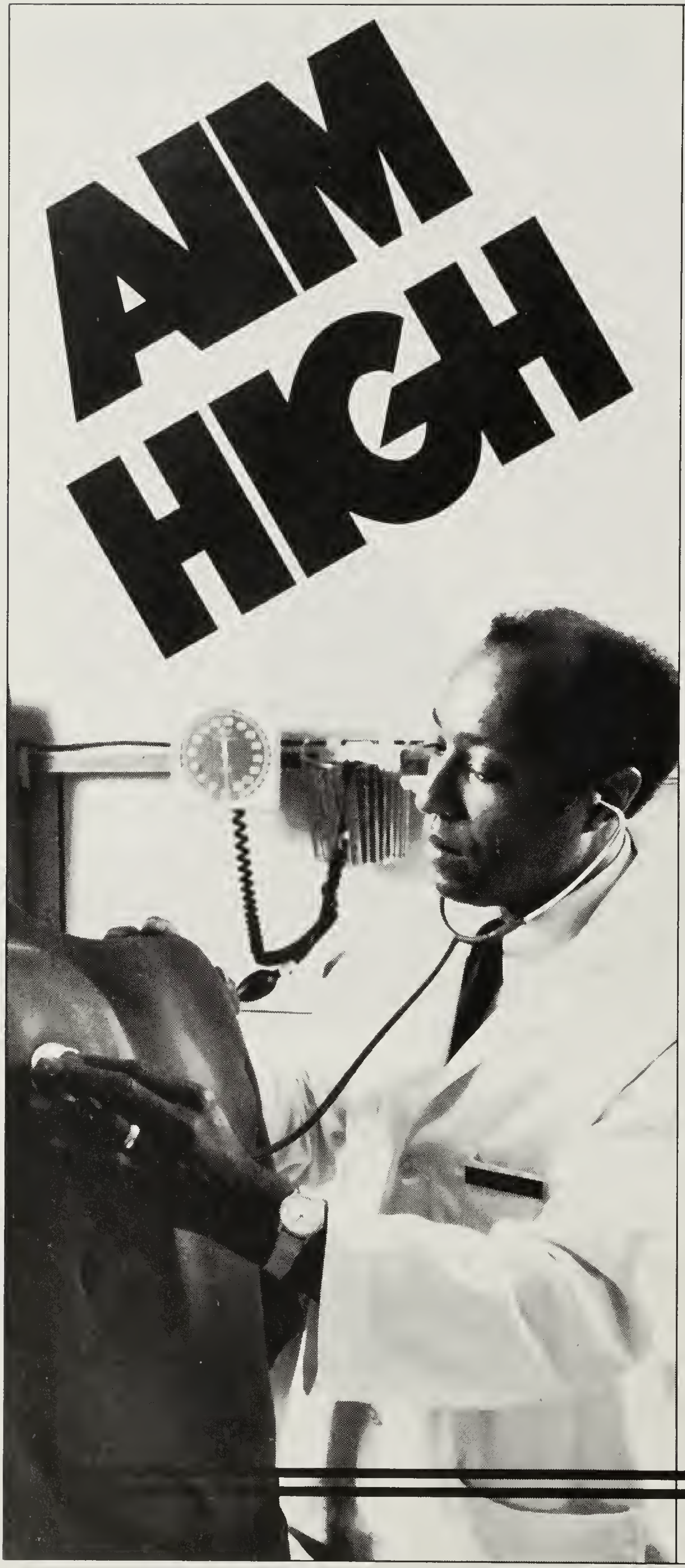

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AIR FORCE

CATEGORY I COURSES

Continued from page 49

16-17, Pediatric Advanced Life Support Certification. Location: Lansing Community College, Lansing, Michigan. **Sponsors:** Lansing Community College. **Contact:** Kathy Hovey, RN, Lansing Community College, 34 - Continuing Health Careers, Health Careers technology, P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-9619. **Approved for:** 16 hours Category I Credit.

18-19, 15th Annual Michigan Fall Radiology Conference. Location: Townsend Hotel, Birmingham, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 14 hours Category I Credit.

23-24, Second International Guillain-Barre Syndrome Symposium. Location: Radisson Hotel, Banhattan Beach, California. **Sponsors:** Wayne State University School of Medicine, Department of Neurology and the Guillain-Barre Syndrome Foundation International. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 13 hours Category I Credit.

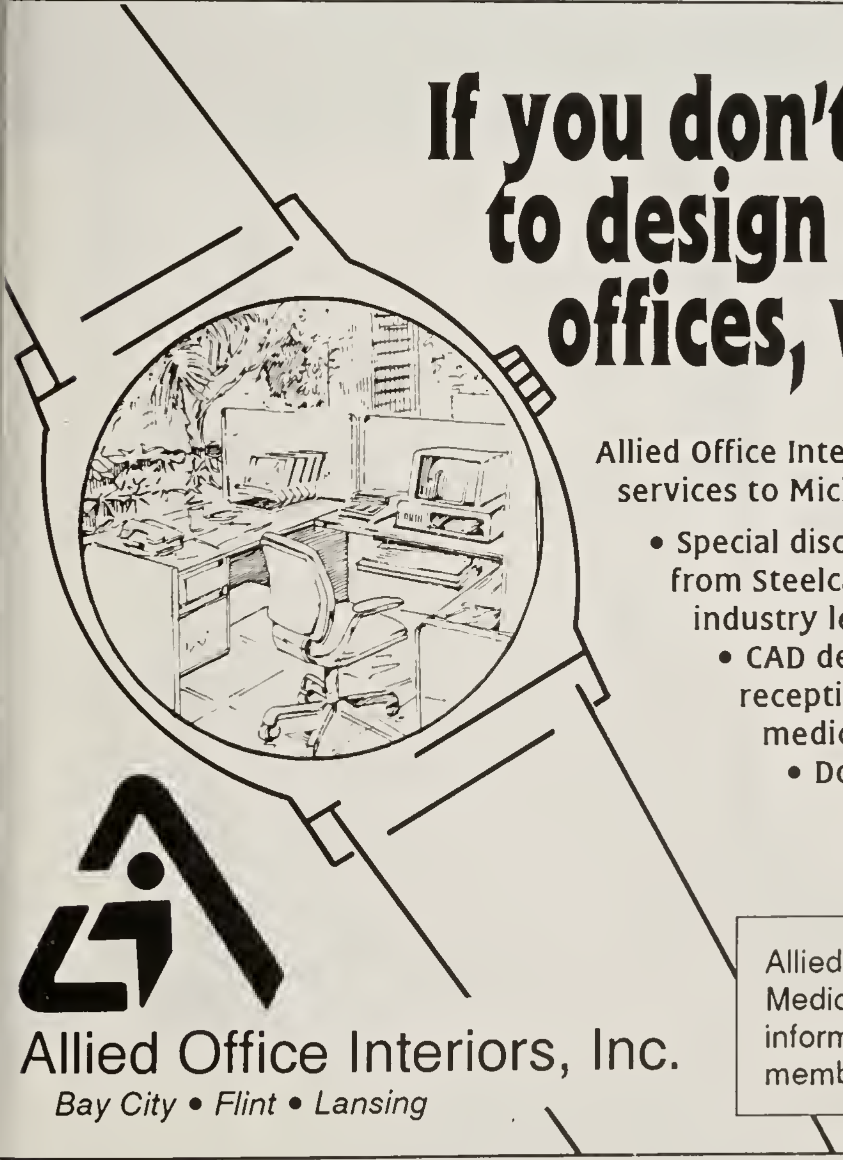
December

5, Grantsmanship: A Model for Success. Location: Holiday Inn South, Lansing, Michigan. **Sponsors:** Michigan Hospital Association, Michigan Health Care Institute, Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Colleen Elliott, Manager, Member Services, MHA/MHCI, 6215 West St. Joseph Highway, Lansing, MI 48917, (517) 323-3443. **Approved for:** 10 hours Category I Credit.

6-7, Advances in Psychiatry. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School. **Contact:** Angela Voeller Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869. **Approved for:** 12 hours Category I Credit.

January

24-26, Advanced Cardiac Life Support. Location: Lansing Community College, Lansing, Michigan. **Sponsors:** Lansing Community College, Continuing Health Education. **Contact:** Kathy Hovey, RN, Faculty/Coordinator, Continuing Health Education P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-1424. **Approved for:** 16 hours Category I Credit. ■



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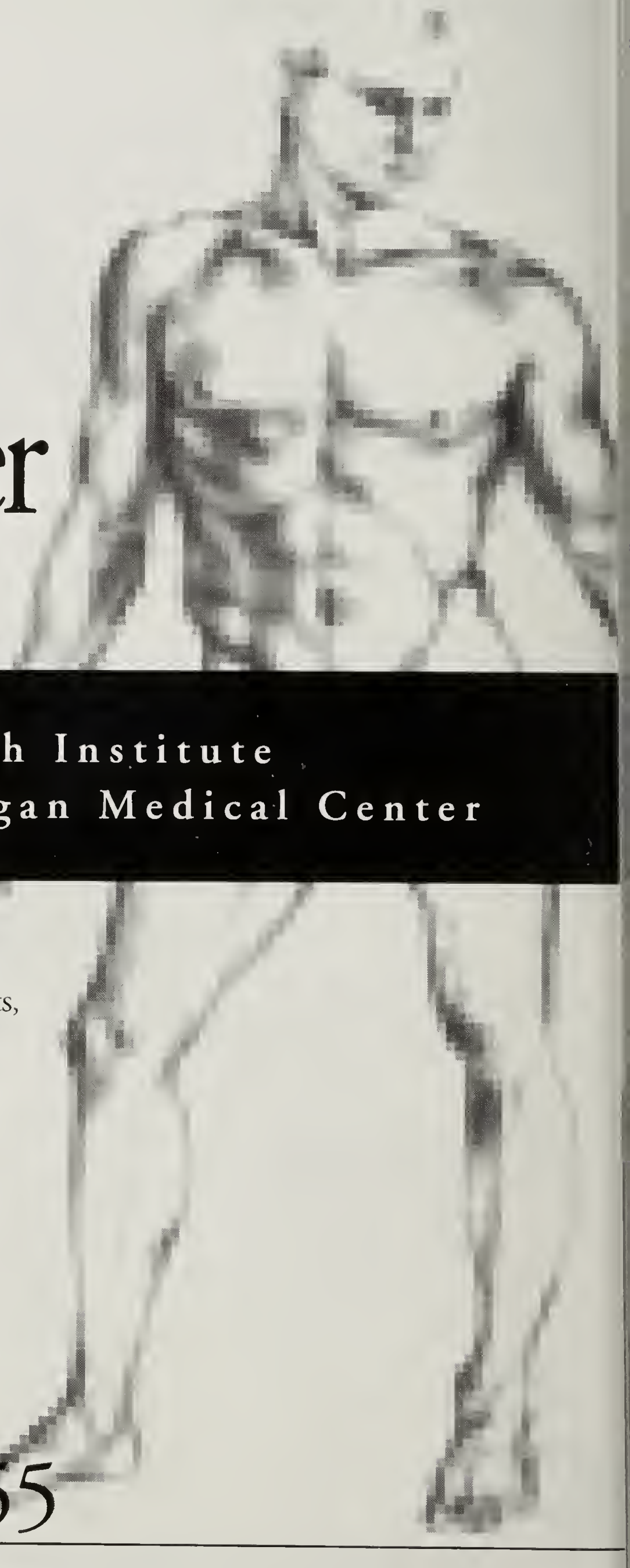

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Continued from previous page

already strong voice in federal legislation fostering accessible, quality health care.

AMA's 16-point plan to improve the US health care system — called Health Access America — is just one example of the AMA's pro-active stance on a nearly endless variety of issues. Through the resources available to the AMA and the collective wisdom of its members, this plan has become the standard by which other proposals are now judged. With widespread physician and patient support, there is every reason to believe this reasonable solution to our health care woes will be looked upon favorably by Congress.

The ability of the AMA to represent the positions of physicians and our patients — on Medicare, Medicaid, AIDS, access, and dozens of others — depends on the strength of the state medical societies, the specialty societies and the county medical societies. Political "clout" emanates up the line from the local, grassroots level. Not accidentally, it is at this level that an individual member has the greatest entree to the federation and the greatest ability to influence the decision making process.

Everyone must be involved

It is at this level that AMA is counting on current members to tell the story of organized medicine to colleagues who have not heard it, or to those who need to hear it again. Each of us must make an extra individual effort to expand AMA membership.

Sometimes I wonder what our health care system would be like without the positive, creative influence of the AMA.

Then I wonder why each of us cannot reach out to a non-member colleague and bring him or her into one of the most democratic, respected and magnanimous organizations in the world.

And frequently I wonder what my life would have been like if Jim Fryfogle, MD, hadn't taken the time and energy to encourage me to become deeply involved in organized medicine. It's astounding the impact one person can have on another person's life. ■

Doctor Burton is MSMS president.

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Henry Ford Hospital	41
Humana Health Care	53
Kelsey Seybold Clinic	34
Kidder Peabody	44
Meade Leasing	47
Medical Automation	43
Medsys	45
Mercy Hospital	48
MI Doctors Political Action Committee	20
MSMS Insurance Programs	IBC
MSMS Group Insurance Trust	4
MSMS Member Benefits	19
MPMLC	IFC
Palisades Pharmaceutical	12
PC Medical Management	44
Physician PracticeLink	54
Physician Service Group	1
Physicians Billing Specialist	45
Physicians Total Care	22
PICOM	13
Prescott, Ball & Turben	54
St. Luke's	33,49
Texel Land Co	31
University of Michigan Medical Center	52
US Air Force	50
Valley City Refuse	51
Zervos Homes	10

PRESIDENT'S PAGE

One Person's Impact

By Robert D. Burton, MD

It's astounding the impact one person can have on your life.

Remember Jimmy Stewart in "It's a Wonderful Life"? How vastly different his hometown would have been without his leadership and integrity.

Another man of leadership and integrity had a profound impact on my life in organized medicine. It was Jim Fryfogle, MD, of Southfield, who served as MSMS president exactly 10 years ago. He has since passed on, but I will never forget him. Jim was my mentor, the man who encouraged me to pursue leadership roles in organized medicine.

It was in 1978, three years before he became president, that Jim sent me a handwritten note. The note read:

"In membership, the majority have the right to decide, the minority have the right to be heard, and the rights of those absent (from the debate) must be protected."

I've always treasured this note. Throughout my various offices in organized medicine, his words have guided me.

The democratic principles expressed in Jim's note reflect just one of the many reasons I enjoy being a part of organized medicine. Our federation's commitment to following the will of its members is second to none.

For example, several years ago the AMA specialty journals were eliminated as a member benefit in a cost-cutting move. Seven specialties continued to receive a copy of their own specialty journals because they were a part of a controlled circulation group, but the move left the family physicians without a journal. After the Michigan delegation, along with other vociferous groups, pointed that out at two consecutive AMA House of Delegates meetings, the AMA recently announced it will begin producing "Archives of Family Practice." The journal promises to give family physicians throughout the country, including isolated rural physicians, the latest medical knowledge in their field.

The AMA is at its democratic finest as you watch a resolution — submitted by an individual physician at the county level — work its way up through the federation to become AMA policy. The voice of the individual is heard and acted upon throughout the process. Debate is open. The decision-making process is accessible. As we have all witnessed in our lives, the world is run by those who show up. It's the same with our federation. An individual's impact is just as strong as he or she is committed to making it.

Individual commitment key

The impact AMA makes as a whole also depends on individual commitment. In Washington, DC, AMA alone carries the banner for thousands of physicians and our millions of patients. The impact AMA makes with legislators for improvements in this nation's health care system is made possible by the numbers of individual physicians committed to speaking up. The AMA's new goal is to have more than half of the physicians in the United States as AMA members by the year 2000, a goal designed to increase our

Continued on page 55

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MICHIGAN MEDICINE

DECEMBER 1991
VOL. 90, NO.12

Award-Winning Journal of the Michigan State Medical Society

Cover Story

Physicians, Patients, Professionals... Unite for Medical Liability Reform

Medical Inquirer

RBRVS

Practice Management

Berrien County Medical Society Profile

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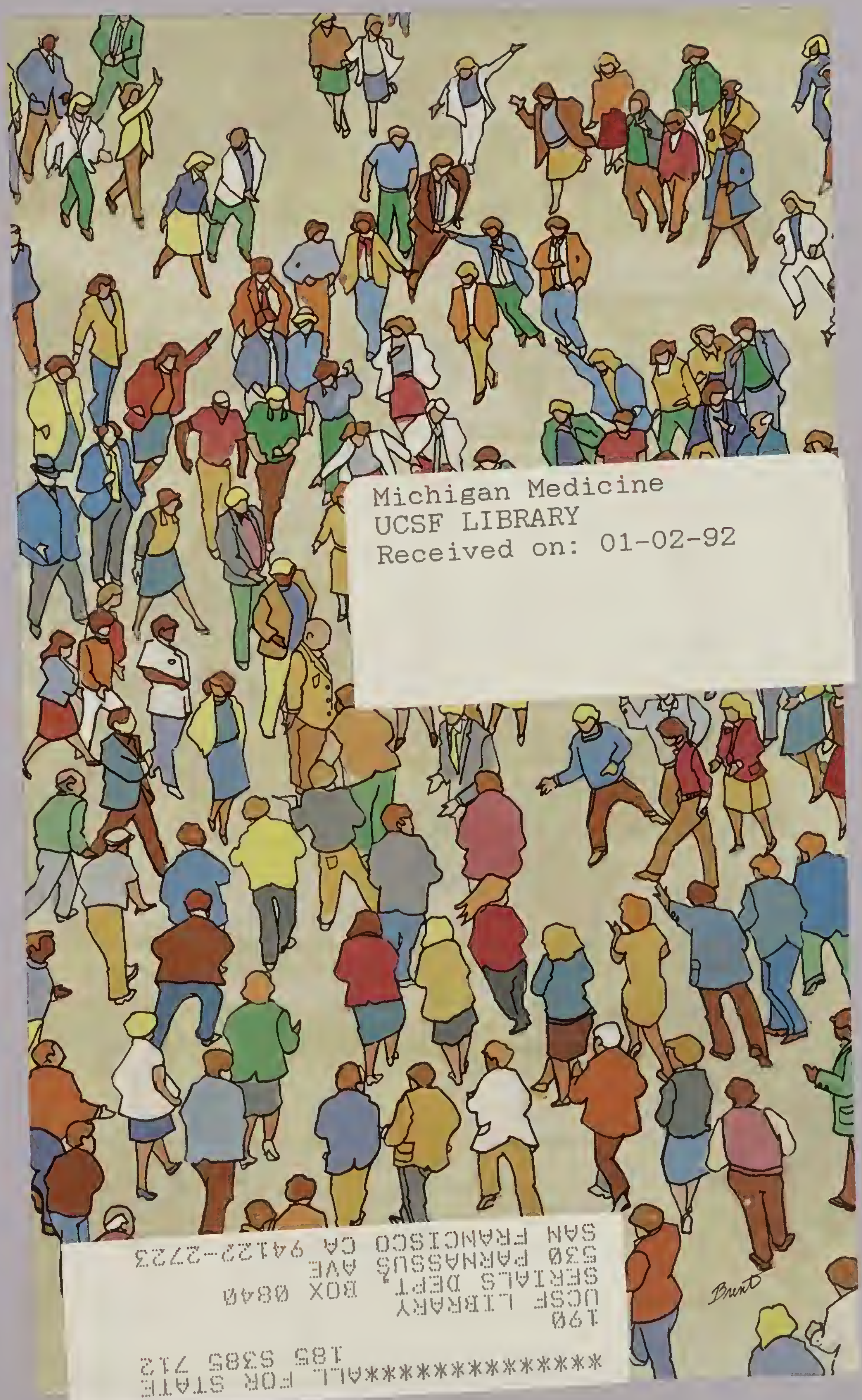

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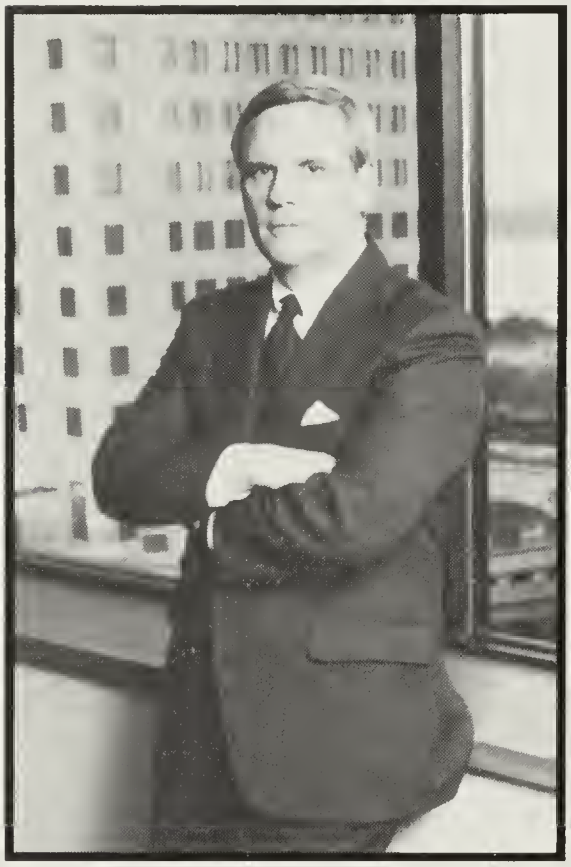

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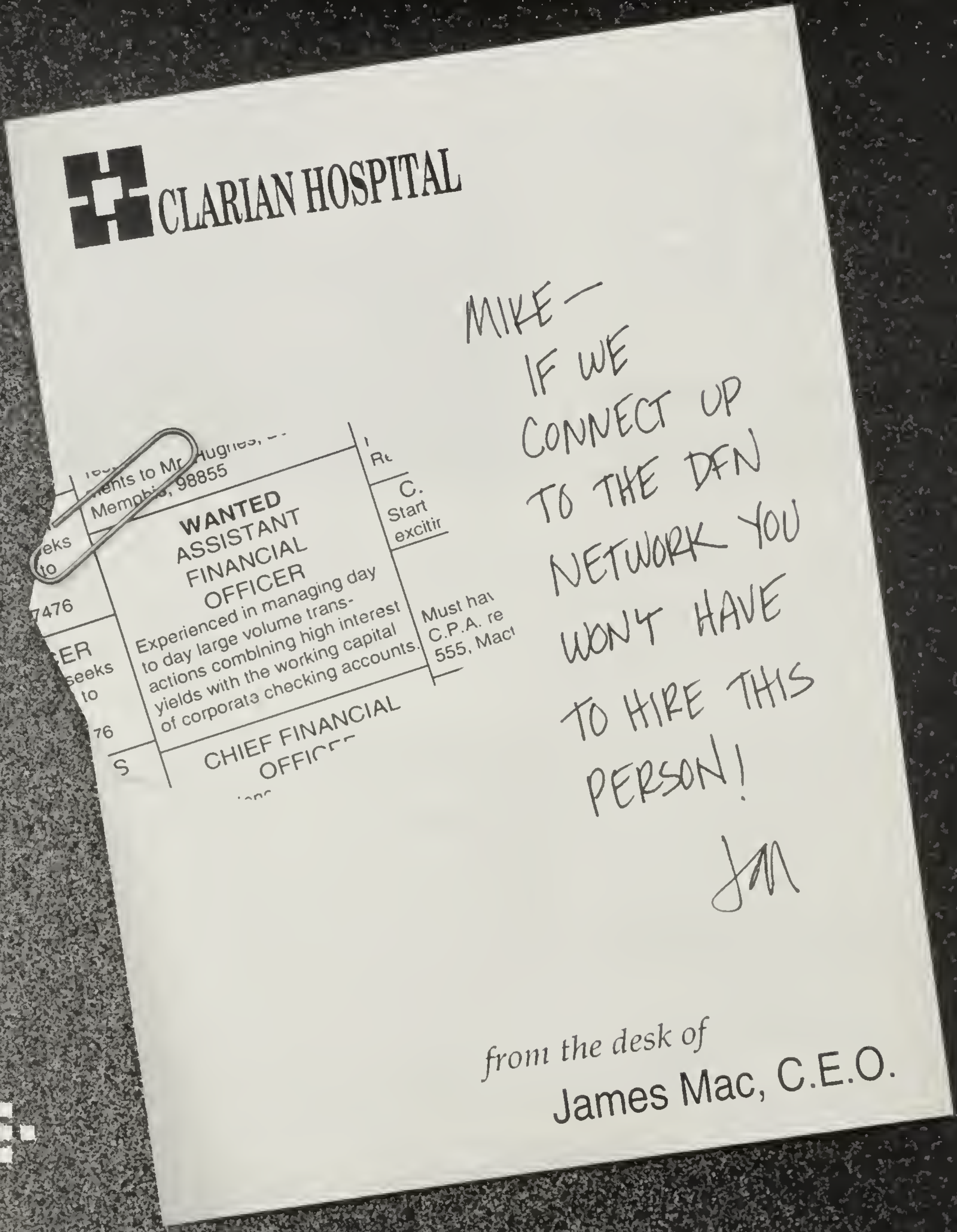

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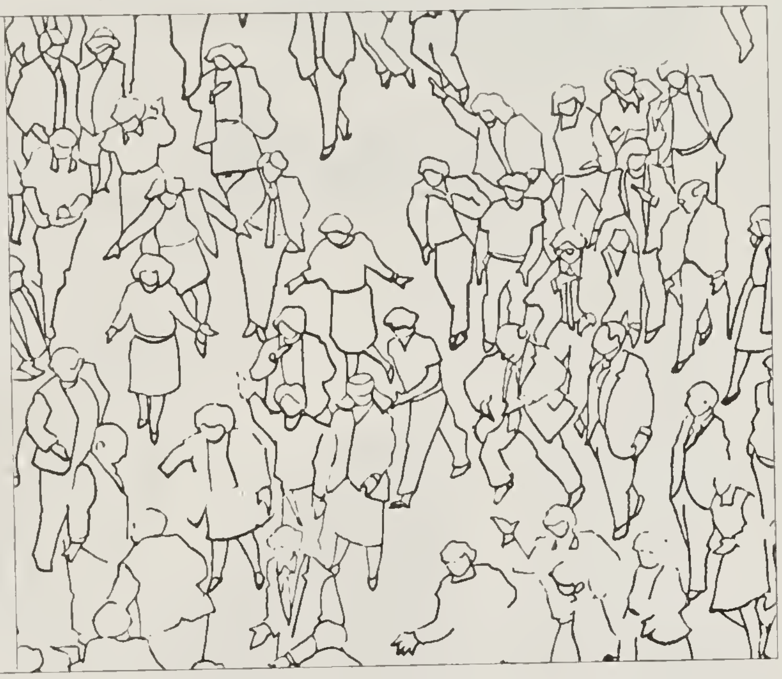
MICHIGAN MEDICINE

DECEMBER 1991 VOLUME 90, NO 12

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

Last month, the Michigan State Senate passed Senate Bills 248 and 249 — medical liability reform legislation. A battle has been won, but the war is not over. The bills must now be passed by the House Judiciary Committee and the full House before a final victory can be declared. This month's cover story is devoted to professional liability. In it you will find a summary of the two bills, a list of the members of the Michigan Medical Liability Reform Coalition, and excerpts of statements given by key supporters of medical liability reform. Also included is a must-read article for all physicians on controlling professional liability exposure through effective communication. These articles and more begin on page 14.



25
Medical Inquirer

This is the seventh in a series of factsheets prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians.

28
RBRVS — Getting back to basics

Though the Resource-based Relative Value Scale will be phased in through the next four years, physicians and their staffs need to be preparing now for the many changes ahead.

By Jeanne Rutledge

31
Practice Management

This second in a new series of articles on practice management examines insurance options and provides useful guidelines for physicians to help them determine if they have the coverage they need.

By Randall W. Braaksma

34
County Society Series

This indepth profile of the Berrien County Medical Society marks the second in a series of articles on county medical societies.

By Marlise A. Michael

DEPARTMENTS

7 MSMS ON THE MOVE

9 MEDICAL NEWSFRONTS

10 PHYSICIANS IN THE NEWS

40 MEETINGS

48 CATEGORY I COURSES

53 CLASSIFIEDS

55 ADVERTISING INDEX

56 PRESIDENT'S PAGE

In next month's issue:
MSMS Membership Directory

Cover illustration: *By Robert L. Brent*

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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MSMS *ON THE MOVE*

A monthly update of key MSMS activities

MSMS leaders/Gov. Engler reiterate need for liability reform

MSMS told Michigan's highest government official recently that medical liability reform in this state is crucial to physicians and patients. MSMS leaders and representatives of the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Hospital Association, and the Michigan Chamber of Commerce met with Gov. John Engler in his Lansing office to discuss creation of a more equitable liability system. Gov. Engler also addressed a recent MSMS Board of Directors meeting, (pictured at left) acknowledging medical liability reform as one of his top priorities. The governor noted that a majority of Michigan citizens also are behind Michigan physicians in calling for reform. Physicians now need to lobby their legislators to push that reform through the Legislature, said Gov. Engler.

MSMS Annual Scientific Meeting offers extensive course agenda

More than 800 physicians attended the 126th Annual Scientific Meeting of the Michigan State Medical Society Nov. 12-14 in Dearborn. Experts updated physicians on many diverse topics, including basic cardiac life support, current psychiatric concepts, reproductive endocrinology, fetal medicine and surgery, clinical approaches to HIV, dermatological therapeutics, and health risks to physicians. Every course provided three hours of Category I CME credit. MSMS contracted with Gavco Audio Visual to tape the courses so that physicians, both those who attended the meeting and those who did not, can review the material covered in the sessions. Physicians may purchase tapes by calling the MSMS Office of Physician Education at (517) 337-1351.

MSMS updates policy on physician-assisted suicide

MSMS strengthened its position on physician-assisted suicide at its Oct. 30 Board of Directors meeting. The Board adopted four points of AMA policy on the issue which will be reported to the MSMS annual House of Delegates meeting May 1-3, 1992. The four points, which the AMA adopted last June at its own House of Delegates meeting, supersede the current MSMS policy established in September 1990. Those four points will remain MSMS policy until and unless the MSMS delegates take further action next May. For further information, contact Katie Brewbaker at MSMS.

MSMS sponsors HIV/AIDS hotline for health care workers

Phone calls to physicians, health care workers, and informational hotlines around the country skyrocketed following Earvin (Magic) Johnson's recent announcement that he tested positive for the HIV virus. The MSMS AIDS Provider Education Project and the Special Office on AIDS Prevention in the Michigan Department of Public Health sponsor the Professional AIDS Information Hotline to answer questions from health care workers on HIV and AIDS. The toll-free line, 1-800-522-0399, is staffed by Wellness Networks, Inc., in Ferndale.

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MEDICAL NEWSFRONTS

MDPH launches new AIDS prevention/anti-smoking campaign

The Michigan Department of Public Health recently launched two new statewide multi-media advertising campaigns, according to State Health Director Vernice Davis Anthony.

The two campaigns are directed toward AIDS prevention and anti-smoking. The campaigns, created by Brogan & Partners Advertising/Public Relations of Detroit and the California Department of Public Health Services, include radio, television, posters and print ads. The ads began airing in November. The campaigns are part of a continuing five-year media program with advertising messages equally divided between AIDS prevention and health promotion.

This year's AIDS prevention advertising is targeted to heterosexual women, teens and other high risk individuals.

The spots include the State hotline numbers for AIDS prevention, 1-800-872-AIDS and smoking prevention, 1-800-537-5666.

Henry Ford chosen as site for $2.5 million Osteoporosis study

Henry Ford Hospital has been awarded $2.5 million for a five- year study to test promising ways to lessen, prevent, or reverse osteoporosis in older people.

The clinical trials, known as "STOP/IT" (Sites Testing Osteoporosis Prevention/Intervention Treatments), will test the efficacy of various therapies designed to stop bone loss from the hip. The trials are being funded by the National Institute on Aging, a division of the National Institutes of Health. Henry Ford Hospital has also been chosen as the coordinating center for the "STOP/IT" program.

Henry Ford Hospital will test the effectiveness of estrogen in slowing bone loss from the hip. The study will be led by Michael Kleerekoper, MD, head of the hospital's bone and mineral division and chairman of the "STOP/IT" steering committee.

Henry Ford Hospital also received funding for two additional studies being conducted in conjunction with the "STOP/IT" program. The two studies will test in further detail why estrogen may or may not be effective in slowing bone loss. Michael Parfitt, MD, director of the hospital's Bone & Mineral Research Lab, will use tetracycline as a measuring device on bone biopsies taken before and after estrogen therapy. Dianna Cody, PhD, a diagnostic radiologist, will use computerized tomography to evaluate the effectiveness of estrogen.

U-M selected as one of two specialized Infertility Research centers

As part of the growing national commitment to research on women's health, The University of Michigan has been selected by the National Institute of Child Health and Human Development (NICHD) as the home for one of two Specialized Infertility Research Centers. The other center will be at Massachusetts General Hospital in collaboration with Harvard University.

The two centers, to be funded for the next five years, will conduct accelerated clinical and basic research related to human infertility. The U-M center has been awarded $709,067 for the first year, with a total recommended budget in excess of $5 million in direct costs for the five years.

Directed by Nancy E. Reame, professor of nursing and reproductive sciences, the U-M center will concentrate on determining why some women fail to ovulate normally.

The U-M researchers will be collaborating on specific research projects with scientists at Wayne State University, Michigan State University and North Carolina State University, as well as with researchers at the Massachusetts General Center and NICHD.

GDAHC studies offer new insights into AIDS care

The Greater Detroit Area Health Council (GDAHC) recently completed two studies on AIDS patient care. The studies, prepared as part of GDAHC's Coordinated Community AIDS Program for Southeastern Michigan (CCAP), provide data that health care providers and policy makers can use to more effectively plan for the delivery of services.

One study, "An Evaluation of Nursing Home Service Delivery for Persons with HIV Infection," tests some popularly held assumptions as to the differences between nursing home residents with HIV and those with other health problems. Some of the beliefs, for instance that HIV residents require a higher intensity of care, were not substantiated by the study.

The second study released by GDHAC, "Cost and Utilization of AIDS Patient Care in Southeastern Michigan...1981-1989," examines the utilization of health care services by persons with HIV, and the cost of providing care. Twenty health care organizations participated, including hospitals, home care agencies and one hospice agency. ■

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PHYSICIANS IN THE NEWS

Three Michigan physicians *recently received Laureate Awards from the American College of Physicians/Michigan Chapter.* They are: **Raymond Mellinger, MD,** Henry Ford Hospital; **James C. Sisson, MD,** University of Michigan Hospital and Medical School; and **Park W. Willis, III, MD,** MSU College of Human Medicine. The award honors physicians "committed to excellence in medical care, education or research and also dedicated to service in their community."

Alvaro A. Martinez, MD, *chairman, Department of Radiation Oncology, William Beaumont Hospital, Royal Oak,* is a newly-named fellow of the American College of Radiology (ACR). Doctor Martinez came to Beaumont from the Mayo Clinic in July 1985 after serving on the staff of the Stanford School of Medicine. His original scientific findings in the field of cancer treatment are quoted in professional journals through the world. His pioneer investigations include studies of the early treatment of breast cancer, the effects of radiation and heat on normal tissues in the treatment of cancer patients and the use of radioactive implants as a form of cancer therapy. His involvement in research led to the development of the Martinez Universal Perineal Interstitial Template (MUPIT), a plastic template used as a guide in radiation treatments for patients with cancer of the cervix, vagina, rectum and prostate. He also developed "The Martinez Technique," a protocol for treatment of ovarian cancer that is used throughout the world.

Myron M. LaBan, MD, FACP, *is recipient of the Recognition Award for Distinguished Clinicians from the American Academy of Physical Medicine and Rehabilitation* (AAPM&R). Doctor LaBan is a past president of the Michigan Academy of PM&R (1981-1983), and is a Commissioner for the Area II Judicial Commission of the Michigan State Medical Society. The Recognition Awards for Distinguished Clinicians are given to honor physiatrists who have achieved distinction through scholarly teaching and outstanding performance in patient care activities. Distinguished Clinicians are noted for their outstanding contributions to both the specialty of physical medicine and rehabilitation and to the AAPM&R.

Ananda S. Prasad, MD, PhD, *professor of medicine and director of research, Wayne State University School of Medicine* is the newly-elected president of the American College of Nutrition. He will serve a two-year term. Doctor Prasad is also president of the International Society for Trace Element Research in Humans (ISTERH).

Evangeline J. Spindler, MD, *has been installed president of the Michigan Psychoanalytic Society for a three-year term, 1991 to 1994.* She is the first woman and first Asian American to be named president of this specialty society. In addition to her private psychoanalytic practice in Ann Arbor, Doctor Spindler is a faculty member of the Michigan Psychoanalytic Institute and the Departments of Psychiatry at the University of Michigan and Wayne State University medical schools.

Charles C. Vincent, MD, *is the new chief of Obstetrics and Gynecology at Detroit Riverview Hospital.* Doctor Vincent joined the hospital's medical staff October 1. He is dean of admissions for the Wayne State University School of Medicine and is former chief of gynecology and vice chief of staff of Hutzel Hospital. ■

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MEDICAL LIABILITY REFORM

NOW IS THE TIME TO ACT

Cover Story

BY THOMAS E. STONE, MD

Last month, thanks to the efforts of MSMS, its Task Force on Professional Liability, members of the Michigan Medical Liability Reform Coalition and numerous individual physicians, the Michigan State Senate passed Senate Bills 248 and 249 — medical liability reform legislation. A battle has been won, but the war is not over. Senate Bills 248 and 249 must now be passed by the House Judiciary Committee and the full House before a final victory for all Michigan physicians can be declared.

Now is the time for each and every physician to put pressure on the members of the Michigan House of Representatives to support this legislation. As chairman of the MSMS Task Force on Professional Liability, **I implore you to call or write your state representative and urge him or her to support Senate Bills 248 and 249 and the companion bills that will be introduced in the state house very soon** by Representatives Tom Hickner, Mike Griffin, Roland Niederstadt and Joe Young, Sr.

This month's cover story is devoted to the professional liability issue. In it you will find a summary of the key provisions of Senate Bills 248 and 249, a list of the members of the Michigan Medical Liability Reform Coalition, and excerpts of statements given by key supporters of medical liability reform. Also included is a must-read article for all physicians on controlling professional liability exposure through effective communication.

I encourage you to read the articles included in this cover story carefully — then take a moment to write or call your local state representative. Act now, every vote counts. ■

KEY PROVISIONS OF SENATE BILLS 248 AND 249

Senate Bill 248

Senate Bill 248 would create a medical liability determination program as an autonomous agency within the Department of Commerce. Under this program, all medical liability cases would be reviewed by three-person panels comprised of an attorney, a physician, and a public member, unless both parties agree to waive this process.

Either the plaintiff or defendant could reject the panel's findings and the case would go to court. If the final settlement or judgment is at least 20 percent less than a settlement offer made by the defendant, the plaintiff must pay the defendants reasonable attorney fees and costs. If the final settlement offer or judgment is 120 percent or more of the defendant's settlement offer, the defendant must pay the plaintiff's reasonable attorney fees and costs.

Senate Bill 249

Attorney Fees Limitation

This provision would enact a sliding scale for the maximum contingent fee for plaintiff's attorneys handling medical malpractice cases. This provision is exactly the same as the Michigan Supreme Court rule repealed in 1981.

Under this provision the maximum contingent fee that could be awarded would be as follows:

A. Not to exceed 40 percent of the first $5,000 recovered.
B. Not to exceed 35 percent of the next $20,000 recovered.
C. Not to exceed 25 percent of the next $225,000 recovered.
D. Not to exceed 20 percent of the next $250,000 Recovered.
E. Not to exceed 10 percent of any amount recovered over $500,000.

Non-Economic Damages

This provision would increase the cap on non-economic damages in medical liability cases from $225,000 to $250,000. However, all of the current exemptions from this cap on non-economic damages would be repealed. These exemptions are:

A. Death
B. Intentional tort
C. A foreign object wrongfully left in the body
D. An injury to the patient's reproductive system
E. Discovery of the injury was prevented by the health care provider's fraudulent conduct
F. A limb or organ was wrongfully removed
G. The loss of a vital bodily function

Expert Witnesses

This provision would require an expert witness to devote at least 80 percent of his or her professional time to either active clinical practice or instruction of students at an accredited health professional school or a combination of the two. The expert would have to practice and/or teach in the same health profession in which the defendant is licensed or, if the defendant is a specialist, in the same specialty or a related relevant area of practice.

180 Days Notice

This provision would require the plaintiff to give a health care professional or health care facility at least 180 days notice prior to filing a medical liability claim. The notice must set forth the legal basis for the claim, the type of loss sustained, and the specific nature of the injuries suffered.

Statute of Limitations

This provision would change the law to require all medical liability actions that arise prior to the age of eight would have to be filed by the patient's 10th birthday and all other actions must be filed within two years of the event giving rise to the cause of action. Currently, if at the time of the alleged negligence the injured party is 13 years of age or less, then a lawsuit can be filed on or before their 15th birthday. ■

MICHIGAN MEDICAL LIABILITY REFORM COALITION

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American Society of Employers
Association of HMOs in Michigan
Greater Detroit Chamber of Commerce
Independent Insurance Agents
Life Insurance Association of Michigan
McNabnay and Associates
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Michigan Association for Local Public Health
Michigan Association of Osteopathic Physicians and Surgeons
Michigan Association of Local Public Health
Michigan Association of Realtors
Michigan Council for Maternal and Child Health
Michigan Chamber of Commerce
Michigan Chapter, American College of Chest Physicians
Michigan Chapter, American College of Surgeons
Michigan College of Emergency Physicians
Michigan Dental Association
Michigan Farm Bureau
Michigan Grocers Association
Michigan Healthy Mothers, Healthy Babies Coalition
Michigan Home Health Association
Michigan Hospital Association
Michigan Insurance Federation
Michigan Manufacturers Association
Michigan Occupational Medical Association
Michigan Ophthalmological Society
Michigan Orthopaedic Society
Michigan Otolaryngological Society
Michigan Petroleum Association
Michigan Pharmacists Association
Michigan Physicians Mutual Liability Company
Michigan Podiatric Medical Association
Michigan Radiological Society
Michigan Recreation and Park Association
Michigan Section, American College of Obstetricians and Gynecologists
Michigan Society of General Surgeons
Michigan Society of Hematology and Oncology
Michigan Society of Hospital Risk Management
Michigan Society of Oral and Maxillofacial Surgeons
Michigan Society of Pathologists
Michigan State Medical Society
Michigan Thoracic Society
National Federation of Independent Business
Physicians Insurance Company of Michigan
Steelcase
United Pediatric Society
Vascular Surgery Associates

As of 11/21/91

Organizations interested in joining the Coalition should contact Kevin A. Kelly at MSMS.

MEDICAL LIABILITY

A serious public health issue

BY VERNICE DAVIS ANTHONY

Following are excerpts of a speech given by Vernice Davis-Anthony, director of the Michigan Department of Public Health, to members of the Michigan Medical Liability Reform Coalition last July.

Reducing the infant mortality rate in Michigan is a clear goal of the Department of Public Health (MDPH). Assuring the availability of prenatal care for all Michigan women has become the cornerstone for attacking Michigan's critical infant mortality problem. This is a need that has been recognized legislatively.

The adverse impact of medical liability insurance costs on access to prenatal care has been well-documented, even if anecdotally. Access to pediatric care in Michigan has also been impacted by medical liability concerns, but it is more difficult to evaluate because of low Medicaid reimbursement for pediatric services.

Access to care is not the only problem which results from our medical liability climate, however. While the effect of medical liability on access to pediatric care is more difficult to demonstrate, there is a clearer connection to the high cost of medical care for the pediatric population that is driven, at least in part, by medical liability pressures.

We have experienced high medical care and treatment costs in the CSHCS program which, we believe, are driven by medical liability considerations. "Defensive medicine" practices are difficult to define, but it appears that some practices by providers are strongly influenced by liability concerns.

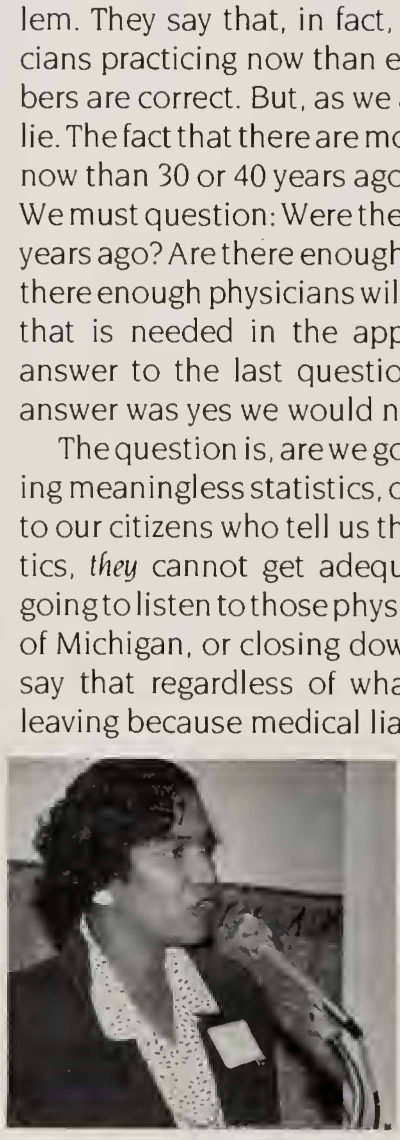
Medical liability problems, although not the only factor, are a primary factor in limiting access to prenatal care for all Michigan women, not just those involved in programs through MDPH. Medical liability problems contribute to an acute shortage of physicians willing to practice obstetrics in any setting. All Michigan women are affected by the shortage, but poor women are more acutely affected.

We have historically had a maldistribution of providers and a bias against the poor that has existed even when the cost of liability insurance was not a concern. However, we believe that liability is a significant and growing factor in what is becoming a serious obstetrical access problem for Michigan and our country.

Those who oppose reform of our medical liability statutes contend that there is no access problem. They say that, in fact, there are more physicians practicing now than ever before. Their numbers are correct. But, as we all know, statistics can lie. The fact that there are more licensed physicians now than 30 or 40 years ago is a meaningless fact. We must question: Were there *enough* physicians 40 years ago? Are there enough physicians today? Are there enough physicians willing to provide the care that is needed in the appropriate setting? The answer to the last question is clearly no. If the answer was yes we would not be meeting today.

The question is, are we going to continue debating meaningless statistics, or are we going to listen to our citizens who tell us that regardless of statistics, *they* cannot get adequate care. And are we going to listen to those physicians leaving the State of Michigan, or closing down their practices, who say that regardless of what others say, *they* are leaving because medical liability is less of a problem in other states?

I think the answer is clear. We know what we have to do, and the time to take action is now. ■



Vernice Davis-Anthony

REGIONAL LIABILITY BRIEFINGS SLATED

Every vote counts in the push for medical liability reform. That's what sixty physicians and hospital personnel in Oakland County learned at the first in a statewide series of regional liability briefings. The briefings are the creation of MSMS, the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS), and the Michigan Hospital Association (MHA).

The briefings entitled, "Every Vote Counts One: Empowering MDs, DOs and Hospital Personnel to Lobby for Liability Reform." are designed to prepare participants to personally contact legislators and urge their support for liability reform.

The next briefing is scheduled for December 17 at Delta College, Saginaw County. Dates and locations of future briefings will appear in coming issues of *Medigram*. For additional information, contact or Judy Marr at MSMS.

CHAMBER OF COMMERCE

Takes an active role in the medical liability reform debate

BY NANCY MCKEAGUE

Following are excerpts of a speech given by Nancy McKeague, director of Government Relations, Michigan State Chamber of Commerce, to members of the Michigan Medical Liability Reform Coalition last July.

The Michigan Chamber strongly believes a comprehensive approach to health care cost containment, including medical liability reform, is necessary to achieve the goals of reducing costs and improving access and quality. Without action, health care spending will continue to escalate. Employees will receive a greater share of compensation in the form of health benefits, and less in direct wages. Fewer employers will be able to provide health care coverage.

For these reasons, the Michigan Chamber earlier this year unanimously adopted a series of legislative priorities relating to health care. That document contains the following statement pertaining to medical liability reform:

"The lack of meaningful progress on medical liability reform continues to have a negative impact on both access and the cost of health care in Michigan. Therefore, the Michigan Chamber strongly urges the legislature and the Administration to make medical liability reform a high priority for action in 1991. Such reform should be comprehensive, seeking to: (1) reduce the incidence of malpractice through improved licensure and discipline of physicians and improved hospital risk management programs; (2) stabilize or reduce medical liability premiums for hospitals and physicians; (3) restore predictability to the medical liability insurance industry; (4) limit non-economic damages for medically-related injuries; and (5) reduce the need for physicians to practice defensive medicine, which drives up health care costs dramatically."

The Chamber is pleased to be part of a cooperative effort with the Michigan Medical Liability Reform Coalition to achieve these goals. ■

Nancy McKeague

MEDICAL LIABILITY

Is an issue for us all, says New Detroit

BY DAVID FUKUZAWA

Following are excerpts of a speech given by David Fukuzawa, director of Human Needs for New Detroit, to members of the Michigan Medical Liability Reform Coalition last July.

For those of you who are not familiar with New Detroit, we are an urban coalition formed in 1967 to improve the quality of life for the people of Detroit. We deal with various issues ranging from race relations to health care. In looking at the issue of infant mortality and morbidity, we realized that it is an issue which cuts across several of our major concerns. Chief among them is access to care.

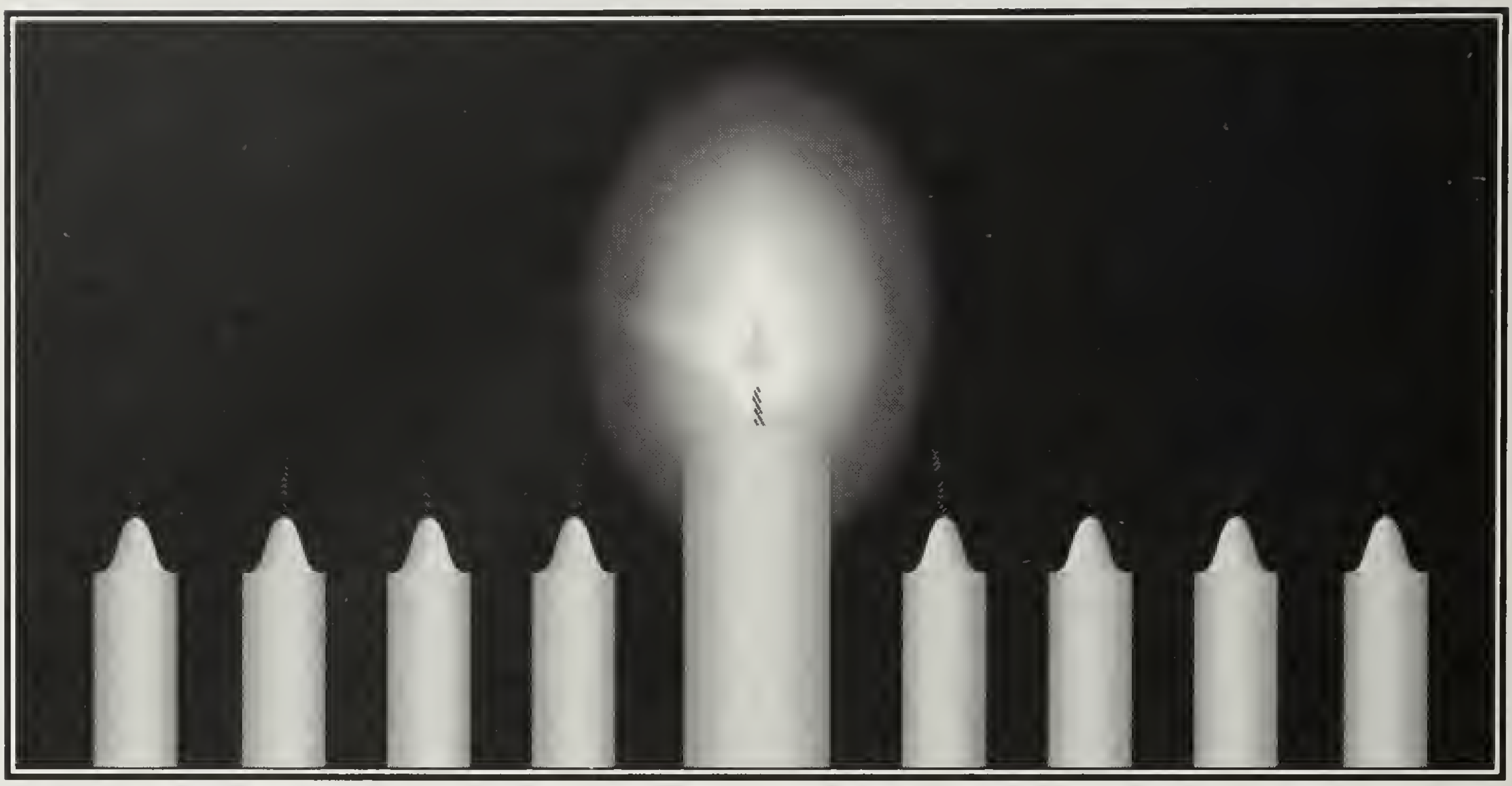
In a city where poverty is dense, such as Detroit, access to affordable, quality health care is usually difficult, often long delayed, and sometimes tragically denied. In the case of women, it has become increasingly clear that as the need for prenatal care is increasing, the number of providers is decreasing.

It is our feeling, and mine as well, that given the impact of medical malpractice liability on infant health in Detroit and the rest of the state, that the issue is too important to be decided among providers, patients and their attorneys. This now needs to become an issue for all of us, especially those of us who are in the family-rearing ages.

Coalitions such as the Michigan Medical Liability Reform Coalition are important. But groups like you need more groups like us. We are concerned that even now the issue of malpractice liability is becoming a political shibboleth, with the Democrats and Republicans lining up on opposite sides of the issue. We cannot afford to let this happen. This is why we must create even broader coalitions, of people and organizations, to let our legislators know that this is not just an issue for providers and attorneys. It is an issue for all of us. ■

David Fukuzawa

LEADERSHIP



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Controlling professional liability risk exposure through EFFECTIVE COMMUNICATION

BY JULIE SMITH

It will come as no surprise to any physician practicing today - especially in Michigan - that the medical liability situation is dramatically increasing the cost of health care, affecting patients' access to care, and limiting physicians' abilities or desires to provide certain services. The causes and potential solutions are numerous; but the fact exists that in most patients' minds, a less than exemplary health care outcome equates to medical malpractice.

While clinical judgement or technical expertise is at times the cause of an adverse health care outcome, non-medical issues often precipitate the filing of a lawsuit or result in a settlement of an otherwise defensible case.

The Michigan Physicians Mutual Liability Company (MPMLC) Claims Department recently developed a list of the 17 non-medical issues most commonly contributing to medical malpractice claims. Of these, three relate to communication between the physician and patient: *inability to communicate effectively, failure to explain a poor and/or unexpected outcome, and poor "bedside" manner.* Closed claim data from professional liability insurance carriers do not usually include a category to specifically track data related to physician-patient communication errors; however, analysis has revealed that problems in this area contribute to an excess of half of all medical malpractice claims.

Direct and indirect effects

Ineffective communication between physicians and patients affects a physician's professional liability exposure both directly and indirectly. An obvious direct effect of poor communication is misinformation. Should a patient misunderstand a physician's questions, he may fail to provide information crucial to a timely diagnosis or may mislead the physician to an erroneous diagnosis. According to Brian Hodge, vice-president of communications at MPMLC, diagnosis-related problems contribute to approximately 29 percent of the claims made against MPMLC insured physicians. Data compiled by Physicians Insurance Association of America, an organization composed of physician-owned insurance companies in 30 states within the nation, reveals diagnostic errors to be responsible for approximately a quarter of the claims seen by these companies.

Patient non-compliance due to misunderstanding of the medical information provided is another way that communication directly affects malpractice claims against physicians, since poor comprehension often contributes to a poor health care outcome. The fact that a patient's behavior may have caused or contributed to their health care outcome does not prevent a patient from initiating or even winning a legal action against a physician. Juries generally believe that physicians have a greater understanding than the patient of the consequences of not adhering to recommended medical treatment. While physicians cannot realistically force a patient to heed recommended care, it is their responsibility to educate patients sufficiently to ensure their understanding of their condition and planned treatment. If it cannot be demonstrated that the physician undertook adequate measures to ensure patient understanding, it may be difficult to defend the claim. However, under the legal doctrine of contributory negligence (the negligent act of a person claiming damages for injury from the negligence of another), the patient's behavior and its impact upon the alleged damages may be used in the defense of a claim. If contributory negligence can be successfully shown (i.e., the patient was provided with the adequate information in order to appropriately comply with treatment) the compensation awarded to the plaintiff may be minimized or non-existent.

Communication with patients also indirectly affects a physician's risk exposure. The failure of a physician to communicate effectively with patients and their families contributes significantly to their impression of the physician and the quality of the professional relationship. The vast majority of patients are not qualified to judge a physician's medical competency, and therefore base their judgement of the physician's competence upon the length and quality of their interactions.

Medical malpractice insurance companies and defense attorneys theorize that one of the major reasons for the large number of claims against physicians is deterioration of the physician-patient relationship. A study conducted by the State of Maine surveyed individuals who had experience with a negative health care outcome. It revealed that only a small number of individuals who could have successfully initiated suit against their physicians actually do so. When interviewed as to how their episode could have been avoided, their response overwhelmingly indicated that more ef-

Continued on following page

Continued from page 19

fective communication could have not only prevented the injury, but also their propensity to initiate suit. Many of these individuals also reported that they actually did not feel that their medical outcome was that bad, but that suing was a matter of principle and a method for revenge. It is the plaintiff, not the attorney, who determines who will become a defendant in a lawsuit. There have been a number of instances in which a plaintiff refuses to involve a particular physician with whom they have a good rapport, even though there is clear evidence of negligence.

A number of factors at play

The ability to communicate effectively is influenced by a number of factors that inhibit a patient's capability to understand and retain the medical and treatment information communicated to them. Most obvious, of course, is whether the information is understood by the patient. Studies indicate that the average patient misunderstands 30 percent to 60 percent of the words commonly used by practitioners. A low level of formal education certainly impacts the patient's comprehension, but misunderstanding of medical terminology used by health care practitioners is potentially a more dominant factor. A study performed by G. E. Collins indicated that patients misunderstand medical terminology to a greater degree than most professionals would expect and even simple medical terms are often misconstrued. She found that *anemia* was confused with *enema* by 80 percent of patients: *well-nourished* was defined as *nervous body* by more than 50 percent, and half the patients thought *maternity* meant a *type of dress*. (See Collins, GE: Do we really advise the patient? J Florida Med Assoc. 42:111, 1985.)

Because this medical "foreign language" is the primary language spoken among physicians and their colleagues, it is often difficult to revert to a language more understandable to the average patient. Physicians who expect a patient's lack of understanding will be more able to effectively interact with patients. Do not assume that some words have lost the obscurity of medical vocabulary due to common use in the media. Explain medical terminology – regardless of how technical the words may or may not be.

In addition to careful explanation, another method for minimizing this dilemma is to compile a dictionary of commonly used medical terms for use as an aid to teaching medical vocabulary to patients. Obviously, such a project would require a great deal of effort and has limited feasibility for general practices. However, the time spent on a dictionary for a specialized practice, such as obstetrics or urology, may prove to ultimately save time in the effort to effectively educate patients.

It is important that the interactions with patients not only aid in the development of a positive relationship, but that the communication instills or maintains the patient's trust in the physician. Advice from a plaintiff attorney is often sought solely to investigate conflicting messages or explanations that the patient has received from the physician. During their depositions, it is common for patients to relate statements made to them by their doctor which "convinced" them that there was negligence. Undermining the patient's confidence in the physician can occur when discussing the inconveniences that the patient will likely encounter during care, when explaining an injury or adverse result, or when speculating on the action of other health care professionals.

Keep patients informed

This can be avoided by accurately and clearly informing patients of what to expect during their treatment. Be honest about anticipated inconveniences such as pain and limitations to daily activities. Avoid conflicting messages by informing patients of the treatment plan and do not change the plan without an explanation. Because patients remember speculative comments as statements of fact, take care when instructing them as to what you or another health care professional will be doing if there is a chance that a different course of action will be taken. When describing diagnostic or therapeutic measures, avoid making a judgement of the propriety or usefulness; it may later be difficult to convince the patient of the appropriateness of this treatment should it become necessary. When suggesting to the patient that unless there is a problem, a certain treatment will not be necessary, it is important to carefully explain the nature of the problem to avoid giving the impression that the "problem" is a result of a mistake.

The patient's anxiety and discomfort at the time of the physician-patient interaction can limit the patient's retention and understanding of information. Measures which increase the patient's comfort or impression that the physician is approachable, and therefore less intimidating, are constructive for increasing the amount of retained information.

Providing written materials related to the patient's condition or planned treatment is also a valuable means for increasing the patient's recall and for furnishing additional information which may be of interest or assistance to the patient. It is important that literature *accompany* verbal interaction and not replace it, since the absence of the verbal interaction may obstruct one of the risk management goals of communication – to foster a positive relationship.

Printed materials related to procedures frequently performed, conditions commonly treated, and medications commonly prescribed in a physician's practice should be available and offered to patients as appropriate. It is important that the literature used be accurate and applicable to the physician's or health care facility's individual policies, protocols and beliefs. Such materials are available from a variety of sources such as health care related organizations or pharmaceutical companies. An alphabetical listing of resources for obtaining printed materials is available from the MSMS Section on Risk Management at no charge.

Recent interest in the need for promoting communication between physicians and their patients has prompted a number of individuals and organizations to develop programs which aid in generating medical literature for patients. In addition, these systems often aid in documenting that the information was provided, a risk management action helpful to providing evidence of contributory negligence. Two such systems include **Clinical Reference Systems, Ltd.**, developed by Denver-based physician David Steinman, MD, and **The Medical Guardian,** developed and distributed by Edward Messina, MD, in Owosso, Michigan.

What to include in your printed materials

Should a physician desire to develop his own printed materials for distribution to patients, the risk management benefits of the literature will be magnified if it includes the following:

For a disease process/medical condition:

- The medical name of the condition as well as any associated layman's term(s)
- Physiology of the disease
- Symptoms, including indications that the condition is worsening or abating
- Causes and/or aggravating factors
- Possible treatments, including medications, procedures and follow-up requirements
- Responsibilities of the patient in the treatment

For a planned medical procedure:

- The medical term for the procedure as well as any layman's term(s)
- Basic description of the procedure
- Reason(s) for the procedure
- Associated risks and benefits
- What the patient can expect during and after the experience, and any recommended follow-up care
- The patient's responsibility, such as preparatory medications, diary maintenance, return visits, etc.
- If a diagnostic procedure, when results will be available and how they can be obtained

Since a patient injury is a necessary element to proving medical malpractice, never is communication more important than after an injury or adverse health care outcome has occurred. There is no guarantee that effective communication will prevent a patient or family from initiating a claim; however, responding sympathetically and non-defensively to the patient's and family's concerns will diffuse much of the anger and confusion that often provide the decision to bring about a malpractice suit.

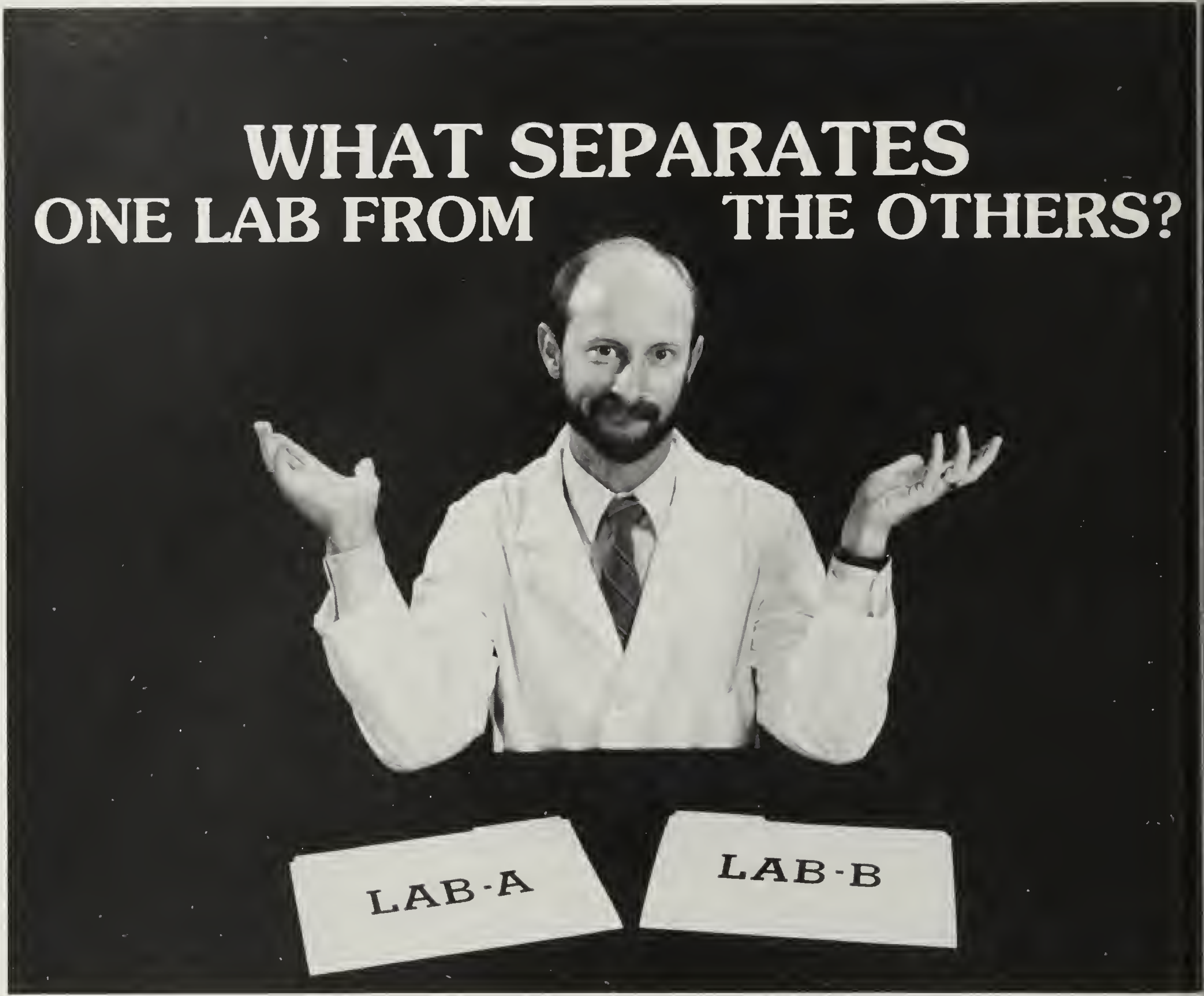
Two common questions of physicians participating in risk management programs addressing communication are "*Should an apology be given*?" and "*Should one admit to a mistake*?" Caution is recommended when "apologizing," and an explanation of the situation, in most situations, is probably more appropriate. An expression of sorrow and sympathy does not imply guilt or negligence, but instead communicates compassion. Stating "I am sorry this happened" is certainly going to be construed by the patient or family differently than "I'm sorry, it was all my fault that you have these problems."

Do not lie

When the physician feels he has personal responsibility for the injury, the specifics of the situation dictate what information should be provided and how this should be communicated. It is *always* beneficial to seek the advice of the professional liability carrier or legal counsel. While each individual situation is different and there is no absolute "blue print" solution for this task, there is one recommendation applicable to all: DO NOT LIE. Altering the facts regarding the situation will cause confusion should other health care professionals explain the situation differently. Not only will this severely discredit the physician and damage the trust and rapport, but if the concealment is discovered, litigation can be guaranteed and evidence of this concealment will most likely be extremely damaging to the physician's defense.

In summary, by ensuring effective communication and promoting the development of positive rapport with patients, physicians are providing their own defense before called upon in court to do so. Consider communication skills to be as important to your practice as surgical expertise and medical knowledge. Some people are natural, effective communicators and others are not. You cannot change who you are, but you can change your ability to recognize that in certain situations, your tendencies may not be the most effective for the patient. ■

To arrange a seminar on this or other risk management topics, or for more information on risk management services, contact Julie Smith, chief of risk management at MSMS.



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MALPRACTICE DEFENDANTS

Can savor sweet victory in recent Michigan Supreme Court decision

BY GREGORY BRUSSTAR

A recent Michigan Supreme Court ruling will improve medical malpractice defense by allowing informal pre-trial interviews with physician witnesses.

The decision, **Domako v. Rowe,** allows defense attorneys more latitude to speak off the record with physicians who have treated the plaintiff. Absent assertion of the physician-patient privilege by a plaintiff, physicians who have treated a plaintiff may now freely meet with defense counsel privately.

MSMS and its endorsed liability insurer, Michigan Physicians Mutual Liability Company (MPMLC), lauded the decision. "This decision will reduce our defense costs by decreasing the number of depositions, promoting earlier case evaluation, and speeding up claims resolution," said Thomas R. Berglund, MD, president and chairman of MPMLC. "Also, this eliminates the plaintiff's unfair advantage during discovery."

"There's a general sense of relief in the defense community," said Monte Jahnke, a partner at the Detroit law firm Kerr, Russell & Weber, and corporate counsel for MSMS and MPMLC. "We're back to the way things were before 1988."

Before 1988, defense attorneys were free to speak to physicians who previously have treated the patient. Informal interviews allowed an attorney to quickly and efficiently determine – simply by making several phone calls – whether his client was at fault or not.

Then in 1988, a bomb was dropped on malpractice defense attorneys. An Appeals Court ruling, **Jordan v. Sinai Hospital of Detroit,** called a halt to any informal (also called ex-parte) interviews between defense attorneys and physicians who had treated the plaintiff. In this ruling, the Appeals Court said informal discussions with the defense about the patient's care violated the physician-patient privilege. Plaintiff attorneys were not similarly restricted because their clients controlled that privilege. This decision was affirmed in 1989 by another case, Lawrence v. Bay Osteopathic Hospital.

Jordan ruling handcuffed defense

Severely restraining defense efforts, the **Jordan** decision required a defense attorney to limit discussions with physician witnesses to the deposition, a formal method of taking pre-trial testimony. Depositions are often costly and time-consuming. Costs include attorney billings from both sides, travel costs, fees from deposed physicians, and transcription costs.

Prohibited from talking to deposed physicians prior to the deposition, defense attorneys went into depositions "blind" – not knowing whether the witness was on his client's side or not.

Jordan overturned: Many overjoyed

Defense attorneys, physicians, hospitals, and liability insurers couldn't be happier about the new Domako ruling, which allows defense attorneys to speak informally with physicians who have treated the plaintiff.

"The Jordan ruling certainly got what it deserved in the Supreme Court," said Vinocur of Smith, Haughey. "From the defense side, this will keep costs down. When you can talk to the physicians you can tell right off the bat if there's a problem or not."

"It's a big win for the defense," said Jacobs of Plunkett & Cooney. "But it's a sad state of affairs when we're rejoicing because of a return to the status quo."

"It's a return to open discovery," added Walter Griffin, partner in the Flint law firm Cline, Cline & Griffin. "Why shouldn't we be able to get the truth?"

William Jack, partner in the Grand Rapids office of Smith, Haughey, Rice and Roegge said, "I was pleasantly surprised by the decision. Now we can get more information earlier on, which means earlier identification of cases that either ought to be settled or ought to be tried."

It's too early to quantify defense cost savings, says Doctor Berglund of MPMLC. However, the impact of the decision has been immediate. "After the ruling, several of our defense attorneys cancelled depositions and went directly to the physicians for the information they needed."

Under the new court decision, the plaintiff still has an opportunity to "assert the privilege" at the case onset by barring the defense from obtaining certain information. But if a plaintiff decides to assert the privilege, any privileged information is inadmissible as evidence – even by the plaintiff. Thus, a plaintiff could damage his own case by restricting access to case information.

Amicus curiae briefs in support of open discovery were filed by the Michigan State Medical Society, the Michigan Hospital Association, and the Michigan Defense Trial Counsel Association. ■

The author is a communications specialist at MPMLC.

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MEDICAL INQUIRER

Liability Crisis Threatens Access to Care

Having a baby or finding other critical medical care is becoming more difficult across the state as Michigan's continuing medical liability crisis is forcing hospitals and physicians to curtail services.

Regional surveys conducted by MSMS prior to hearings of the Senate Subcommittee on Medical Liability point out the need for immediate and effective new laws to check liability costs and direct millions of dollars into delivery of medical care. Michigan's current liability system sends only 37 cents of every medical liability dollar to patients. Most of what is left, about 49 cents, covers legal costs, according to a 1991 study by one of the nation's top actuaries, Tillinghast Co. of Atlanta.

In the last five years, average payouts per paid claim have risen rapidly - a 41 percent increase for Michigan Physicians Mutual Liability Company (MPMLC) and 87 percent for Physicians Insurance Company of Michigan (PICOM). The number of new claims against these two major physician insurers is increasing again. The dip following the glut of suits filed to beat the deadline before the 1986 tort reform went into effect is over. The insurance companies expect this trend to continue.

How physicians have reacted across Michigan

SOUTHEAST

1. 75% reduced or restricted services.
2. 87% believe there is an access problem
3. 74% avoided/concerned about ER trauma cases
4. 64% difficulty recruiting partners and staff

OAKLAND COUNTY

1. 74% reduced or restricted services.
2. 85% believe there is an access problem
3. 71% avoided/concerned about ER trauma cases
4. 61% difficulty recruiting partners and staff

WEST MICHIGAN

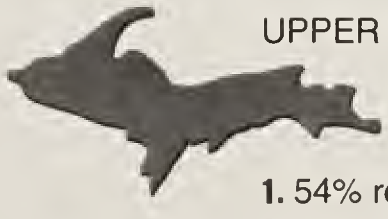
1. 57% reduced or restricted services.
2. 72% believe there is an access problem
3. 60% avoided/concerned about ER trauma cases
4. 56% difficulty recruiting partners and staff

NORTH CENTRAL

1. 83% reduced or restricted services.
2. 81% believe there is an access problem
3. 76% avoided/concerned about ER trauma cases
4. 87% difficulty recruiting partners and staff

THE THUMB

1. 83% reduced or restricted services.
2. 98% believe there is an access problem
3. 88% avoided/concerned about ER trauma cases
4. 81% difficulty recruiting partners and staff



UPPER PENINSULA

1. 54% reduced or restricted services.
2. 72% believe there is an access problem
3. 67% avoided/concerned about ER trauma cases
4. 62% difficulty recruiting partners and staff

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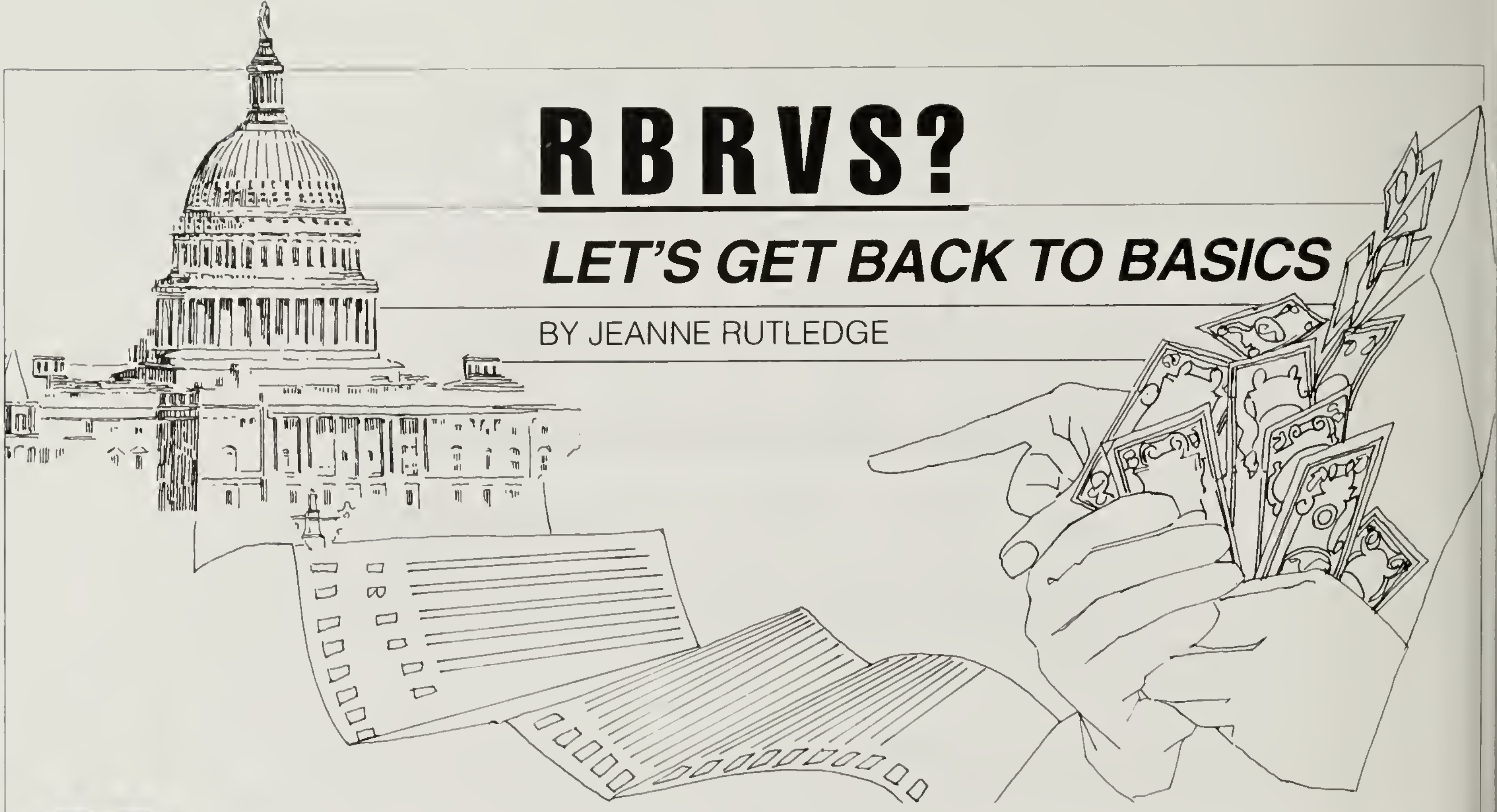

RBRVS?

LET'S GET BACK TO BASICS

BY JEANNE RUTLEDGE

Most Physicians are aware by now that the Resource-Based Relative Value Scale (RBRVS) will be phased in through the next four years. This system will forever change the method by which Physicians are paid for services that are provided to Medicare patients. It also will establish national guidelines for coding, billing and payment. Most coding experts believe that it will change the entire reimbursement system.

What most physicians are not aware of, however, is that they and their staff need to be preparing for these changes *now*. Whether you have a significant percentage of Medicare patients in your practice or not, you need to be concerned about sweeping changes that are coming in billing and coding. Heightened awareness of three areas; coding definitions; guidelines of billing; and coding and reporting should be, at the very least, what you garner from all the literature written on the RBRVS.

Coding definitions

Are you confident that your biller(s) and coder(s) are familiar with level of care definitions? You can be overcharging, but in most cases we find physicians understating the care they are providing to their patients. One key change in the new ruling is the use of visit codes in place of the previous medical visit codes you were using. The same issues, as when they established the existing medical codes, are still concerns; standardizing the definitions for proper use; use of time in coding; patient condition; and the relationship of the patient in your office. This still adds up to the significance the proper usage of procedure codes will play and the importance of understanding the "levels of care." In one family practice setting we were able to increase the revenue by 30 percent through the correct use of codes. The biller was undercoding the physician's services contrary to what the medical record showed. In another multi-physician family practice we were able to defuse an audit. The physicians had *appeared* to be over utilizing a particular level of office care. This triggered an audit by the local HMO. The reality of the situation was that the biller was using the limited office code (90060) over 90 percent of the time. The medical records confirmed the inaccurate use of the code. Instead of being sanctioned by the HMO and being monitored for one year, the physicians actually increased their revenue because they had provided, in most cases, a higher level of care to the patient than what was reported by their biller. Whether it is billing for Medicare services under the RBRVS or billing to other carriers, understanding the definitions and utilizing the codes correctly are paramount to obtaining proper reimbursement.

Guidelines of billing

Secondly, do you and your biller understand the combination of services that you can provide? Unbundling of services is a major issue in HCFA's proposals. Contrary to previous rulings, HCFA has specifically addressed and set guidelines more dramatically than ever before. For example, rules on global surgical billing and rules on minor surgical procedures are much more extensive. Does the office with a low percentage of Medicare patients need to be concerned? This area, more so than any other, will begin to shape how all carriers are going to reimburse for surgical and non-surgical services. Is your biller current with existing guidelines? If you are *not* utilizing the codes properly now you will have a difficult time adjusting to the new rules. Be sure that your biller is updating skills to attain this level of expertise within your practice. You should be able to rely upon the biller to give you advice on billing guidelines for *all* insurance carriers.

Coding and reporting guidelines

Finally, just as important are the billing and reporting guidelines. Is your biller using modifiers correctly? Is the biller aware the impact modifiers play now, let alone when the HCFA proposed standardization of modifiers occurs? We find many billers who are not aware of the importance of modifiers, let alone the correct use of them. Is your biller familiar with reporting guidelines? Many billers, even the ones who have been with a physician five to 10 years, need a better grasp of simple reporting rules. Just because a claim gets paid does not mean it was paid correctly. Could the reimbursement have been increased? Just because a procedure code is paid by a particular carrier does not mean the guidelines were used correctly thus causing a situation where the practice can be audited years later. In one multi-specialty practice we worked with, the biller was using a consultation code with a surgical code. The two procedures separately are *payable benefits* by the Blue Shield Plan she was billing. However, when billed together in the way she was reporting the codes, it was not a *billable service*. This particular practice had to pay back over $200,000 to the Blue Shield plan. One physician said they never knew the biller was doing this. The biller asked, "What is the difference between a non-payable service and a non-billable service." Does your biller know the answer to this question?

Whether you have studied the RBRVS literature in-depth and have decided it does not affect you, or you have had a biller for six months and you are not sure of her skills, or your biller has been with you for eight years and you are confident your billing is being done correctly... in any of these situations, you need to be sure that your biller understands the basics. Coding definitions, guidelines for billing and billing and reporting rules are the basics. Do you, the physician, understand their subtle differences, do you understand their importance? Does your biller understand their importance?

More than ever, knowledge of coding and billing is a must requirement of all billers and physicians. RBRVS has brought this to the surface for many physicians, for others it has always been important. Yes, RBRVS will force many practices to tighten their billing and coding methods. However, accurate coding should be the "career" of all billers whether billing Medicare or any other carrier. The practice who spends time on the basics will be the least affected when changes occur and may benefit from the changes. The practices who do not, will be most affected and will constantly be working to catch up with changes. ■

Jeanne Rutledge is president of Medical Management Systems of Michigan, Inc., a medical billing and consulting company

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ARE YOU COVERED?

Insurance can be complex and confusing. These guidelines can help with the first step – **Determining whether you have the coverage you need.**

BY RANDALL W. BRAAKSMA

One insurance company uses a red umbrella for its logo to represent total coverage. Another uses the Rock of Gibraltar, a symbol for the peace of mind the right insurance can give. But as any health care professional who has purchased insurance knows, there is often a great distance between symbol and reality.

This article is about bridging that gap. It is based on the comments of Terry Walsh, president of Stratton, Cheeseman & Walsh, Inc., the MSMS-endorsed insurance agency. What follows is a general overview of a physician's business insurance needs. Use it as a guide in discussions with your insurance agent to make sure your coverage is right for you.

Business Owner's Policy

There are five types of coverage all doctors should consider. The first is the Business Owner's Policy (BOP). It is probably the most important coverage a physician can have because it provides property and liability coverage for the office. The BOP is designed for normal, routine business practices. Because it's a standardized policy and risks are spread over a large number of businesses, the premium on a BOP is usually less than if you'd add coverage to a basic policy.

The BOP covers:

- the building if you own it;
- all contents of the building, including medical equipment, furniture, fixtures, improvements, supplies, office equipment, virtually everything that's in the office;
- business interruption, which provides for loss of income because a disaster prevents you from using your office, plus extra expenses coverage for up to 12 months to relocate in temporary quarters; and,
- liability for bodily injury, property damage, and personal injury.

Building and contents coverage

It's important to note that the building and its contents are covered under the BOP on a replacement-cost basis. That means there is no deduction for depreciation in case of a loss. The policy gives you new-for-old, paying you whatever it costs to replace the old with the new.

When deciding on how much to insure contents, calculate what it would cost to replace them today, not what they are worth. Many doctors make the mistake of looking at their dated fixtures and old equipment and deciding to "save money" by opting for less coverage than they would get under a BOP. They "saved money" until a loss occurred.

Say, for example, you furnished your office 15 years ago with exam tables and other medical equipment. You have a loss – fire, storm, whatever. Under an insurance policy other than a BOP, the insurance company would say, "This stuff is old, it's not worth much. We'll give you 25 cents on the dollar." In the case of the exam table you originally bought for $500, you now have a settlement

Continued on following page

Continued from page 31

from the insurance company for $125 to replace a piece of equipment that costs $1,000 today.

Business interruption coverage

Business interruption coverage is automatically included in a BOP. If you can't use your office to practice because it's been damaged – partially or totally – it covers you for loss of income. It also includes extra expense coverage for up to 12 months. These are the costs you would incur to move into temporary quarters while your office is being repaired or rebuilt.

Again, some doctors aren't convinced that business interruption coverage is necessary – until a loss occurs.

Liability coverage

BOP liability coverage excludes malpractice insurance but includes bodily injury, property damage, and personal liability insurance.

If a member of the public – one of your patients, a mail carrier, a pharmaceutical salesperson – is injured on your premises, the bodily injury liability coverage of the BOP would cover claims against you.

If you are a tenant in a building and do something that damages it, you could be held liable. Property damage liability coverage under the BOP protects you against a claim. And finally, claims against you for libel, slander, defamation of character, or invasion of privacy – which may result, for example, from an employee revealing sensitive information about a patient – are covered under the BOP's personal liability coverage.

A fourth liability coverage that is optional but highly recommended is non-owned auto liability. This covers the doctor in the case of an employee who, while using his or her own car to run an errand for the doctor, has an accident that seriously injures someone. The doctor could be held liable because he sent the employee on the errand for the practice. This coverage would protect the doctor against this liability.

Four optional BOP coverages

While the BOP provides blanket coverage, it can be beefed up by adding optional coverages in several areas. The **first** is accounts receivable coverage. This covers the doctor against the inability to collect money that is owed to him or her because records have been destroyed.

The BOP isn't for everyone

The standard Business Owner's Policy is a little like a one-size-fits-all garment; it works for most physicians – those that own their buildings or lease space – but not everyone. A major exception is those doctors who are involved in a condominium building, either with other health care professionals or with hospitals. A condo arrangement has specific re-quirements. Check with both your insurance agent and your attorney to make sure your coverage is right for you in the event of either a major or minor loss. You will probably need to start with a basic policy and add specialized coverages as appropriate.

This coverage becomes less important as more and more doctor become computerized and keep a backup file of their accounts receivables on a disk or tape that's stored off premises. Also, because a great deal of the money a doctor receives comes from third party payers, primarily insurance companies, there is little reason to believe they would withhold payments if a doctor's records were destroyed.

A **second**, much more useful optional coverage is called valuable papers and records. If you decide that you will completely reconstruct patient records if they are lost in a disaster, this coverage will handle those costs.

In the vent of a loss, the regular BOP covers only the cost of the paper in your files as an office supply. Having additional valuable papers and records coverage will pay the costs for someone – your staff or outside professionals – recreate your patient files. It's not unusual for record replacement costs to run to $30 per patient record or more. Multiplying that cost times the number of your patients will give you a good estimate as to how much extra coverage you'll need. And, as your practice grows, you should increase coverage accordingly.

A **third** optional coverage involves computers. Again, the regular BOP covers any loss or damage to your computer equipment, but not your software or the information stored on your files. Optional computer coverage would pay the costs of replacing software and reconstructing information (accounts receivable, patient records, etc.) which you had stored on disks and hard drives.

The **fourth** optional coverage is air conditioning and equipment breakdown insurance. It's only for a doctor who owns or is responsible for his or her building. If you are and, for example, your rooftop air conditioning unit is struck by lightning or is damaged in a storm, your BOP would cover repairs. However, if electrical or air conditioning equipment just stops working, this optional coverage would cover the costs of repairing mechanical breakdowns.

Worker's compensation

The second major type of coverage is Worker's Compensation. Michigan state law requires that all physicians who have one full-time employee (someone who works 35 hours or more per week) or three part-time employees (someone who works less than 35 hours per week) carry Worker's Compensation insurance.

This insurance covers any employee who is injured on the job. If you have incorporated your practice, you should include yourself under this coverage. Doctors often do not carry enough disability insurance. Covering yourself under Worker's Compensation at a small additional cost is a good way to pick up the slack.

Finally, Worker's Compensation laws vary from state to state. If you have practices in more than one state, not uncommon for doctors located near state borders, you should check with your insurance agent to make sure your coverage is appropriate.

Automobile insurance

If you are incorporated and your corporation owns or leases a vehicle for your use or the use of your employees in running errands or transporting patients you need the third major type of coverage–automobile insurance. In order to be properly insured, you must name the corporation as owner or lessee on the insurance policy.

That may seem obvious until you consider the one-person corporation. Many doctors in this situation buy or lease a car in the name of the corporation and then insure it under their personal insurance policy. In the event of a loss, their insurance companies find that the car is owned by one entity, the corporation, and insured under another. This discrepancy provides the insurance company with a legal way to deny a claim. It's one instance where your business and personal lives must be kept separate.

ERISA bond

The Employee Retirement Income Security Act of 1974 requires that if you are a corporation you carry an ERISA Bond, the fourth major type of insurance coverage. This federal law states that anyone who acts as a fiduciary (someone in control of funds) or a trustee of an employee benefit plan be bonded in the amount of 10 percent of the assets handled.

Congress enacted the law to protect employees in large corporations. There had been instances of people in charge of pension and retirement funds using the money illegally. The resulting law is so all-encompassing that it includes all businesses with these types of funds. If you are part of a corporation that has a pension or profit-sharing plan and act as its trustee or fiduciary, you need this coverage.

Umbrella policy

The image of the umbrella brings us to the fifth and final major coverage–the Umbrella Policy. Guessing where you may need additional coverage and in doing so leaving some areas with less than you need can be dangerous. The Umbrella Policy solves this problem by increasing coverage for all liability exposures except malpractice.

The coverage is inexpensive and is available in multiples of $1 million. Here's how it works. You decide to purchase an additional $1 million of Umbrella Policy coverage. An employee driving your corporation's vehicle has an accident and seriously injures someone. He sues your corporation for $2 million in damages. Your automobile insurance includes liability coverage to $1 million, but you're covered; the additional umbrella coverage automatically comes into play and increases your coverage to $2 million.

The key to the Umbrella Policy and the other four major coverages mentioned here is your specific situation. You might find that your circumstances demand more than these coverages can provide.

What we've tried to give you here is the background you need to take the next step – asking your insurance agent to review your coverage and recommend a plan that meets your needs. ■

Randall W. Braaksma is a East Lansing-based Freelance writer

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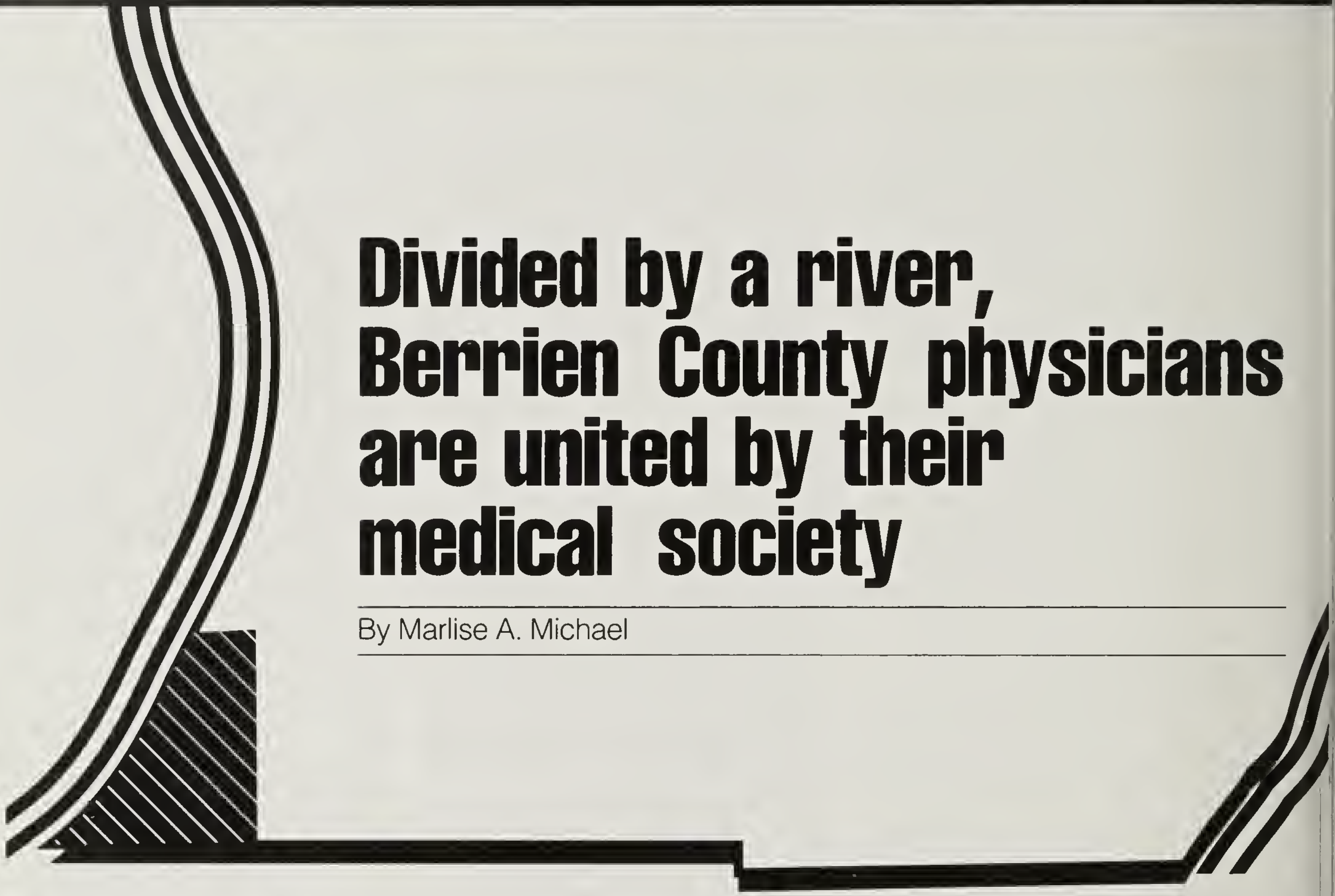
MEMBERS NYSE/SIPC

Divided by a river, Berrien County physicians are united by their medical society

By Marlise A. Michael



What comes to mind when you think of Berrien County and its medical community? Physicians driving all night on snow covered roads to beat the stork. Country doctors taking care of everything from pediatrics to geriatrics. Some might even say, "I didn't know Berrien County had a medical society." In fact, being one of Michigan's smaller medical societies, Berrien occasionally gets lost in the crowd on state and national levels, but the physicians do not seem to mind.

Berrien's numbers keep growing

Like Ingham County, Berrien County is considered a "cabinet county," because it was named after one of Andrew Jackson's cabinet members - John Berrien, who served as attorney general. Although early Berrien activity centered around the city of Niles, this cabinet county is composed of several cities including Benton Harbor, Bridgman, Berrien Springs, Buchanan, Eau Claire, Galien, New Troy, New Buffalo, Stevensville, Three Oaks and Watervliet. Coloma, another Berrien city, is the location of the present Berrien County Medical Society (BCMS).

The Society, as it exists today, was organized in 1901 under the American Medical Association plan. The first recorded official meeting of Berrien's medical society was in 1906, held at the Library Hall in Benton Harbor. There were 34 members listed on the roster.

Today, Society membership has grown to 190, including 30 retired members. "The county population centers are very localized," said Eunice Ott, BCMS executive director/secretary. "St. Joseph-Benton Harbor is one population center and Niles is the other. The physicians concentrated in those locations have the same kind of community interests and living standards, unlike larger cities in which physicians come from so many diversified areas."

BCMS is a small, friendly organization, according to Ms. Ott. "We live in rural communities and the physicians are very close knit and know each other real well. Most of the organization's membership has been long-time, although within the last four to five years, we've had an influx of new physicians. Hospitals are recruiting very earnestly in the last two years because we haven't had ultra-specialty type practices in this area. Those people who have needed certain specialties have gone off to larger communities, like South Bend or Kalamazoo, so in order not to have that happen to our hospitals and our areas, we have recruited new physicians and those new physicians are now members of our society causing us to see a chance in the organization."

Included in that change is the influx of a large number of international medical graduates who have joined BCMS over the past 20 years. Incorporating them into the Society and getting them to participate is one of the Society's goals.

BCMS also is encouraging involvement with medical students. Although the Society is not affiliated with a medical school and does not have any medical student members, BCMS does support the county's student population with a medical student loan fund. So far, BCMS has granted about 30 student loans, six within the last two years.

"I'm surprised at the number of students who have gone into medicine in this country," says Henry Klos, MD, a Berrien physician who has been editor of the BCMS bulletin for more than 35 years. "We have a hard time keeping money in the fund. It originally was limited to southwestern Michigan, but now all the student recipients are from Berrien. Initially, the fund was created with the thought that we would build a relationship with these future doctors, but I don't know of one that has stayed."

BCMS camaraderie

Recent BCMS meetings have covered legal issues and litigation, marketing and medical malpractice. At first, most of the topics were CME accredited. Now credits are given at the hospital level and BCMS members are more interested in broader topics, says Ott. "Even if they aren't interested in the topic we are featuring, they come for the sociability, and to see their friends and their colleagues."

The Society also invites spouses to their dinner meetings.

As the executive director/secretary, Ott is the person in charge of organizing these meetings. As the

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Continued from page 35

Society's one and only staff member, she also wears many other hats.

Operating the BCMS office out of her home, Ott is responsible for keeping the records, maintaining the roster and books, scheduling meetings and arranging for speakers. She also serves as hostess, answers the phone, takes minutes, records dues, and types the monthly bulletin.

In addition, Ott provides support to BCMS's executive committee which meets every month. This committee consists of the president, immediate past president, president elect, secretary, treasurer, public health chair, public relations chair, editor of the bulletin, program chair and four delegates.

The 1991-92 president is Robert Clark, MD, a specialist in pathology, who is surprised to find himself holding the presidential reins of BCMS. "I thought I would have a year to get used to things as president-elect," he said, "but at the second meeting, my predecessor left the county and I had to take over." Membership has not been a problem, according to Doctor Clark. "When I became president, I thought that would be an easy area to tackle, but there was no market to improve on. We have a high percentage who do pay dues."

Although Doctor Clark says long-term goals for the Society are in the developmental stages, Berrien would like to become more involved in educating the community. "We want to get together and find out what's happening with the public, and especially the elder population.

The Society consists of many groups divided by age, specialty, and culture, and each one has his own set of priorities, according to Doctor Clark. "It's really a collection of many societies. Today, the young doctors have an incredible amount of debt. Doctors with families have people depending on them. Older doctors are burnt out. What we all have in common is that we enjoy each other's company."

Although new to his presidential post, Doctor Clark said that he already has learned something about organized medicine: at the county level, it is not a "viable factor to equal the forces of government. I don't see how people trapped in a practice can be effective spokespeople if they don't have the time or energy to do so. It makes me concerned about medicine in this country."

The Society gets varied attendance at political seminars, according to Doctor Clark. Basically, everyone is flat out working too hard. All we can get most of our members to do is sign letters. We try to keep up with all the educational activities, but the doctors are all working their tails off here and a lot of the physicians do not understand the issues." BCMS is not a very political society, according to Doctor Clark, but there are one or two Berrien doctors who attend state functions.

Clinton Wilson, MD, is one of the physicians the Society depends on for explanation of legislation and the politics of medicine. Interested in both local and state issues, Doctor Wilson is a member of the practicing physicians advisory committee to the Health and Human Services Department in Washington, manages weekly conferences at Mercy Memorial Medical Center, and runs a farm "for fun."

"As is the case with most medical societies, involvement in the political arena is limited to whoever will take the time to be involved," Doctor Wilson said. "It sort of fell on me by evolution. I represent BCMS and our local hospitals more at the federal level than at the state level. Our involvement in 1991 has been dedicated to the payment reform mechanism that is now being debated. Our stand has been similar to the stand of the rest of the medical communities across the states which is that the proposed 16 percent cut by HCFA in reimbursement, and the regulations of the laboratory and the limitation of the private physician to conduct laboratory tests and be reimbursed is not acceptable. On both of those counts we have been very successful."

Prior to those issues, BCMS initiated the implementation of a program in malpractice arbitration. In Michigan, prior to 1990, when a malpractice case went to mediation, the mediators were selected by the lawyers. "We felt this was not fair," Doctor Wilson said. "The only way to make it fair was to have the mediators contacted by the clerk of the court so they would have no knowledge about the side they would represent and who selected them. In 1990, that was enacted in our district. We took that to the state, which has accepted this in most of the other districts in the state.

Physicians don't get involved in the AMA because they can't afford it, according to Doctor Wilson. "It's a matter of economics in our little part of the world here," he said. "The primary care physician suffers tremendously. The average primary care physicians now is Michigan are struggling and finding it hard to survive on a taxable income less than $50,000. That is because our income is fixed which is due to the fact that most of the patient load is of the Medicare/Medicaid variety."

Doctor Wilson feels that BCMS participation recently has increased primarily because physicians see the Society as a representative for them at the state and federal level. "They see that their input through their representatives has made a difference," Doctor Wilson said. "I think that has stirred up enthusiasm for the Society, which has become very viable. I think the physicians, particularly the younger physicians, feel there is a job that can be accomplished by intervention into the system, both at the state and federal level."

BCMS confronts local challenges

Like the other medical societies, BCMS members who want to become more active in organized medicine can join one of their standing committees. BCMS has 11: public health, membership, the bulletin, counseling, public relations, aged, credentials and ethics, legislation, mediation, and program. Because Berrien County is located in the area of two nuclear plants, BCMS also has a disaster and hospital liaison committee.

"The Cook nuclear plant borders on the south, and Palisades is on the north," Ms. Ott said. "So Berrien county lies right in the middle. They have practice sessions rehearsing disasters, how emergency rooms would function, how the doctors would be summoned, how the public would be informed and the routes to take."

The Society also works closely with the American Red Cross on blood drives, has a referral service and holds a gala affair once every five years to recognize retired physicians, life members, and those who have done special work.

Although progress has been made to draw Berrien physicians together, the county still is divided into the north and south. Such divisions may be illustrated by the story of the Berrien hospitals.

Six years ago, there were two hospitals - Mercy, which was located in Benton Harbor, and Memorial stationed in St. Joseph. Divided by a river that separated them into east and west, both hospitals were dominated by strong men, and quickly became intense rivals.

Stanley Banyon was chair of the Board of Trustees of Mercy Hospital. He also was the publisher of a

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Continued from page 37

newspaper and owned a radio station.. Chair of the Board of Trustees of Memorial was a man named Fred Upton, who also was one of the two founders of Whirlpool Corp.

Each were described as powerful, wealthy public leaders who were possessive of their institutions and wanted a hospital in their own community. Attempts to merge the two had been made in the past, but neither could come together, according to Doctor Klos. "Memorial built a bigger hospital in St. Joseph. I thought it would reduce the tension, but the hospital staffs chose up sides, making physicians of Mercy and Memorial also rivals," he said.

It wasn't until the 1980s that the rivalry came to a close when Banyon died and Upton was no longer a part of the Whirlpool Corp. Whirlpool then decided it was not going to continue to waste money on two hospitals, so the boards got together and combined the two hospitals to what is now Mercy Memorial Medical Center located in St. Joseph.

"It's working out fine as far as physicians are concerned," Doctor Klos said. "Some older board members say they resent it, but it's functioning. Now they have a very ambitious administration, whose long range plan is to centralize the hospital's medical care in southwestern Michigan and set up a preferred provider corporation." But that's not the end of Berrien's consolidations. The merger of Mercy Memorial and another Berrien county hospital is expected to be finalized before this year comes to a close, according to Ms. Ott. "Really, there are four hospitals in Berrien County - Mercy Memorial Medical Center, Berrien General, Watervliet Community and Pawating. Pawating in Niles and Mercy Memorial Medical Center in St. Joseph are in the midst of a merger that will happen this year. To keep the people in our communities from leaving their own area and going to larger cities for service, we had to combine services, allowing for a broader scope of practice."

Now that they are in the process of merging, the majority of physicians in the south where Pawating is located are in favor of the merger, according to Doctor Klos.

Many physicians have moved to Berrien to get away from the large urban districts. In 1950, Doctor Klos moved out of Detroit because he "didn't like the big city. I wanted to go to a smaller community and St. Joseph fit. It was sophisticated and rather prosperous and a headquarters of a world corporation, close to Chicago. It's a pleasant community and Berrien County is a good place to practice medicine." ■

The author is managing editor of the *Detroit Medical News*, a publication of the Wayne County Medical Society.

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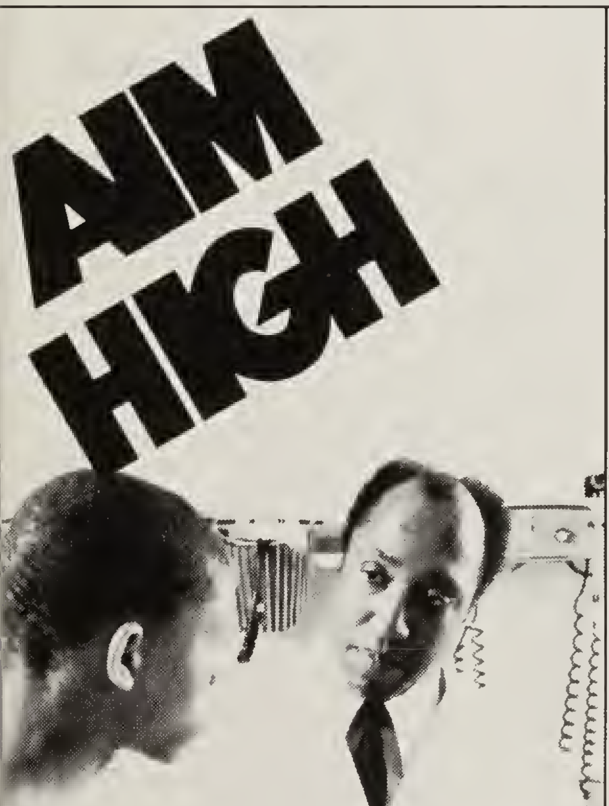

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MEETINGS

MSMS Meetings

January

16, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

March

14, MSMS Joint Section Meeting, Dearborn Inn, Dearborn, MI. Contact: Judy Marr, Manager, Department of Communications and Professional Relations, (517) 337-1351.

18, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

26-27, MSMS Conference on Maternal & Child Health, Hyatt Regency, Dearborn, MI. Contact: Lori Randall, Chief, Physician Education (517) 337-1351.

May

1-3, MSMS House of Delegates, Hyatt Regency, Dearborn, MI.Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

Michigan Specialty Society Meetings

February

11-12, 1992 Director's Conference Healthy Communities: Expanding Partnerships for Chronic Disease Prevention. Contact: Michigan Department of Public Health, (517) 335-8389.

National Specialty Society Meetings

December

15-18, Scientific Conference on the Application of Magnetic Resonance to the Cardiovascular System. Contact: American Heart Association, Resonance to the Cariovascular System, Scientific and Corporate Meetings, 7272 Greenville Ave., Dallas, TX 75231-4596.

January

16-18, American Academy of Pain Medicine's 1992 Annual Conference. Contact: Carol Endicott, (708) 966-9510.

March

27, Academy of Psychosomatic Medicine 39th Annual Meeting. Contact: Executive Director, Academy of Psychosomatic Medicine, 5824 North Magnolia, Chicago, IL 60660, (312) 784-2025.

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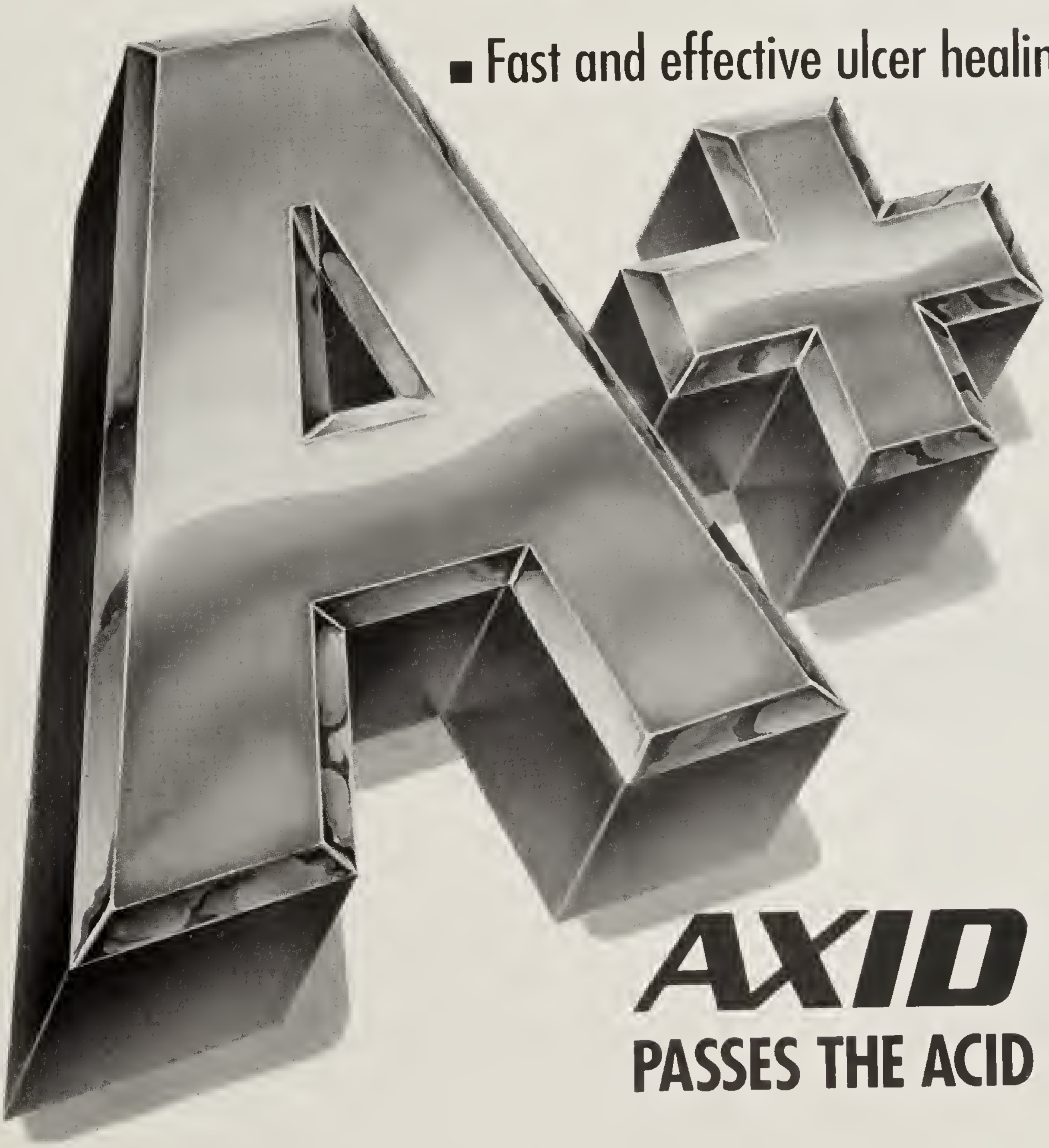

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

January

24-26, Advanced Cardiac Life Support. Location: Lansing Community College, Lansing, Michigan. **Sponsors:** Lansing Community College, Continuing Health Education. **Contact:** Kathy Hovey, RN, Faculty/Coordinator, Continuing Health Education P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-1424. **Approved for:** 16 hours Category I Credit.

26-29, Second Annual Midwinter Symposium for Primary Care Physicians. Location: Harbor Cove, Harbor Springs, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, Director, CME, MSU/KCMS, 1535 Gull Rd., Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 7 hours Category I Credit.

27-29, Fiberoptics Workshops for the Difficult Airway. Location: Disney's Yacht and Beach Club Resort, Lake Buena Vista, Florida. **Sponsors:** University of Michigan Medical School and Department of Anesthesiology. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869. **Approved for:** 15 hours Category I Credit.

February

2-7, Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsors:** University of Michigan Medical School, Department of Family Practice and Michigan Academy of Family Physicians. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

8, Advanced Cardiac Life Support Recertification. Location: Lansing Community College, Lansing, Michigan. **Sponsors:** Lansing Community College, Continuing Health Education. **Contact:** Kathy Hovey, RN, Faculty/Coordinator, Continuing Health Education P.O. Box 40010, Lansing, MI 48901-7210, (517) 483-1414. **Approved for:** 6 hours Category I Credit.

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CATEGORY I COURSES

28 - Mar. 1, Advances in the Management of Infectious Diseases: Update 1992. Location: South Seas Plantation, Captiva Island, Florida. **Sponsors:** University of Michigan Medical School. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

27-29, Advances in the Management of Infectious Diseases. Location: South Seas Plantation, Captiva Island, Florida. **Sponsors:** University of Michigan Medical School. **Contact:** Tami Gibson, Registrar, Office of Continuing Medical Education, Box 1157, University of Michigan Medical School, Ann Arbor, MI 48106-9869, (313) 936-9800 or 800-962-3555. **Approved for:** 14 hours Category I Credit.

March

5 - 8, Intensive Review of Geriatric Medicine. Location: William Beaumont Hospital, Royal Oak, Michigan. **Sponsors:** William Beaumont Hospital. **Contact:** Division of Geriatric Medicine, William Beaumont Hospital, (313) 551-0622. **Approved for:** 32 hours Category I Credit.

6 - 7, Endoscopic Sinus Surgery. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

8-11, Fiberoptics Workshops for the Difficult Airway. Location: Red Lion's La Posada Resort, Scottsdale, Arizona. **Sponsors:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

17- 21, Family Practice 1991 - 15th Annual Spring Review Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Family Practice. **Contact:** Angela Voeller, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-9869, (313) 763-1400. **Approved for:** 35 hours Category I Credit.

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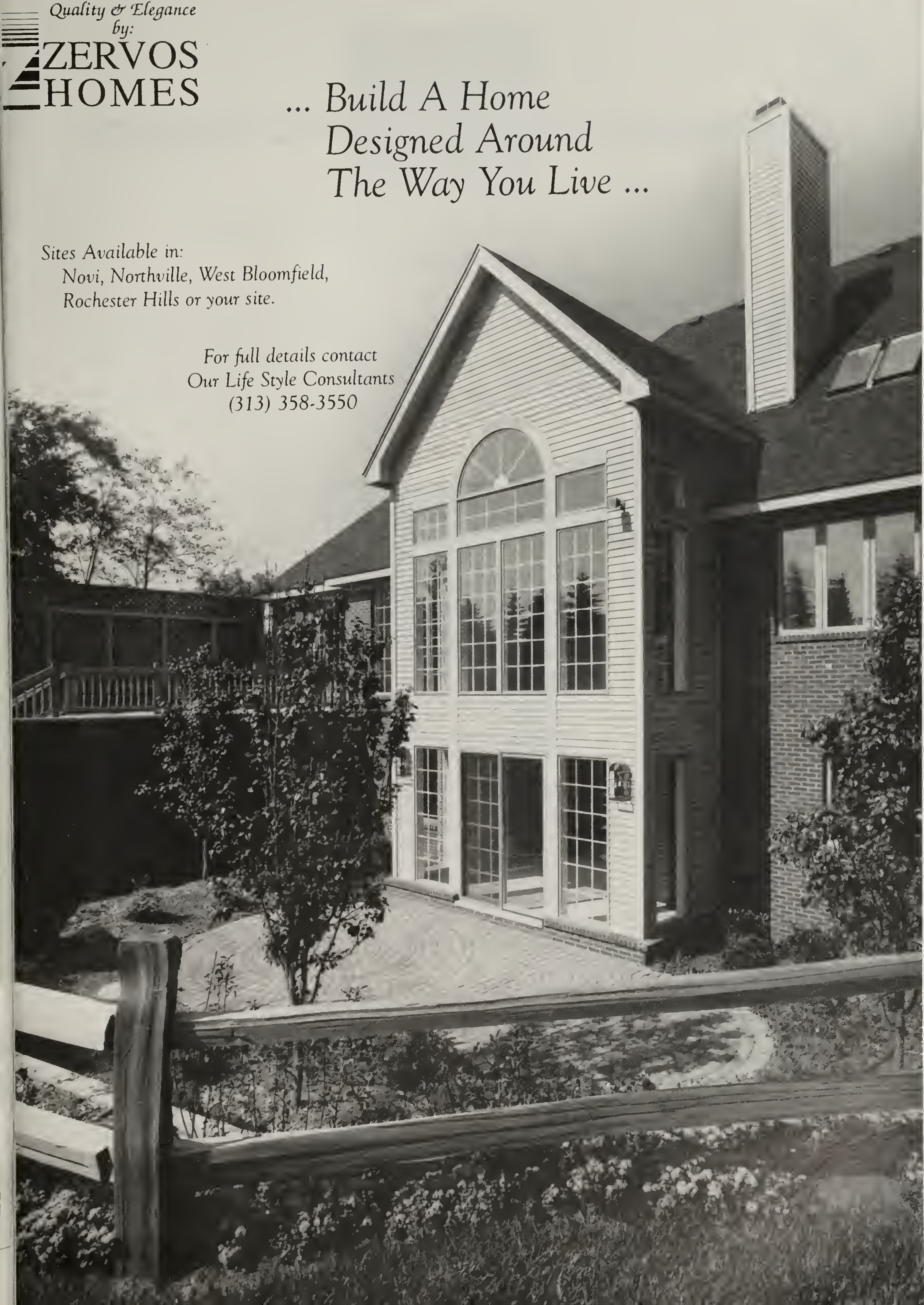

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PRESIDENT'S PAGE

The Holiday Season — A Time for Renewal

By Robert D. Burton, MD

As we approach the hectic holiday season, listen to what a few of my literary "friends" have said and see if you fit in.

"More men are killed by overwork than the importance of the world justifies" – from "The Phantom Rickshaw" by Rudyard Kipling, 1888.

"I wear the chain I forged in life." – from "A Christmas Carol" by Charles Dickens, 1843.

"It is well to superintend the sick to make them well, to care for the healthy to keep them well, also to care for one's own self, so as to observe what is seemly." – from "Precepts" by Hippocrates, 420 B.C.

"Physician, heal thyself." from The Holy Bible, Book of Luke, Chapter 4, Verse 23.

My point is simple. All too frequently, we physicians find ourselves facing a frenetic, frantic schedule. An inhuman schedule. A superhuman schedule. We have unending demands upon our time and our skills and our emotions. Which is exactly why we went into this wonderful profession in first place; because we want to help people in need.

However, every physician, no matter what his or her stamina and energy level, also has needs as a human being. We must realize we have the same needs as our patients. We need to take time for renewal – spiritually, emotionally and intellectually. We need to recharge the batteries, and there's no better time to do it than during the holidays.

My prescription for every physician this coming holiday season is to plan some private time for personal renewal. Some complain that the holidays are among the most hectic of year, with obligatory parties and social functions, shopping, and travel. So how do you fit personal renewal in there?

My first recommendation is to plan ahead. During holidays past, my family has planned everything from major travel adventures to simple church worship. Both resulted in the same net effect – a personal feeling of renewal. I recall one Christmas morning nearly 20 years ago waking up to the sound of a hundred church bells pealing over the snow-covered fields of a small town in Switzerland; a truly moving experience. But equally moving is simply attending our home church's Christmas Eve candlelight service.

Your plans do not have to be extravagant. Just set the time aside to be with family and friends and then stick to it.

My second recommendation is to just say "no" to some of the obligatory functions during the holidays. Sometimes it seems we are trapped at the center of a whirling vortex of holiday events. To pull ourselves free, we must grab for the "no" rope. It's not easy to do, but you'll find the results worthwhile.

Physicians. We are serious people on a serious mission. We are givers. Yet every day we are threatened by legal matters, we are harassed by third-party payors, we are bumped, buffeted and knocked by every special interest that thinks it knows how better to deliver health care to those in need. It's enough to make you sick. And if you're not careful, it might.

This holiday season, you owe it to yourself, to your family, and to your patients, to take some time to revitalize, recharge and remember just why you got involved in the healing arts. You must care for yourself, "so as to observe what is seemly," as our friend Hippocrates said.

Happy holidays! And may we enjoy a lasting peace on earth. ■

Doctor Burton is MSMS president.

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